POLICY OPTIONS REGARDING SURPLUS ACCUMULATION IN THE WASHINGTON HEALTH INSURANCE MARKET

The Office of the Insurance Commissioner

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Report

"Policy Options Regarding Surplus Accumulation in the Washington Health Insurance Market,"

Prepared by The Lewin Group

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The LEWIN GROUP

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EXECUTIVE SUMMARY

In the last few years, the public's focus on the financial activities of health carriers has intensified. A series of events led to a particularly intense focus on carriers in Washington. First, carriers in Washington, like health carriers nationwide, started experiencing large increases in their earnings. Second, the economy softened at the same time that health care costs swelled. This increased the state's numbers of uninsured and made it harder for those having insurance to afford it. Some stakeholders argued that Washington carriers should give up portions of their surpluses to help make health coverage more affordable.

The Washington State Office of the Insurance Commissioner (OIC) commissioned The Lewin Group (Lewin) to develop methods to assess whether Washington's domestic carriers have "excess surplus", and if so, how the term could be defined and how any "excess surplus" held by a domestic carrier could be regulated, including whether a single standard should be applied to all licensees. Lewin conducted a broad-based, general review of the Washington market and Washington domestic carriers, focusing primarily on four Washington health carriers: Regence BlueShield (Regence), Premera Blue Cross (Premera), Group Health Cooperative (GHC) and PacifiCare of Washington (PacifiCare). The report does not include an analysis of these carriers' affiliates except where noted. Further, the project did not involve the actual modeling of the target surplus ranges for Washington domestic carriers.

There are many ways to measure surplus including months of premium, risk-based capital (RBC) ratio, and surplus as a percent of revenue (SAPOR). SAPOR measures capital and surplus ("surplus") as a percentage of insured premium revenue net of reinsurance ("total revenues"). A key question with regard to any surplus assessment is whether there is a "right" level of surplus or single standard for all carriers. The level of surplus required to provide an adequate margin of safety is a matter of judgment, and experts do not agree on a "right" target surplus level for a health carrier. The NAIC, as one interested party, only addresses the RBC minimums needed to ensure solvency, and further asserts that RBC is not an appropriate tool to use at higher levels of surplus. Carriers contend that a carrier wants to provide an adequate margin of safety so that the company can endure periods of adverse experience without triggering any form of regulatory intervention. Thus, the "right" level is carrier-specific. It is not a single number that regulators can apply to all carriers.

Policy Options for Regulating Surplus

There are numerous policy options with regard to surplus regulation. We provide brief summaries of these options below.

Capping Surplus

- **Key issues:** Advocates often look to capping surplus as a strong policy option for state insurance departments in limiting surplus accumulation amongst carriers.
- **Advantage:** The primary advantage of capping surplus levels is that it may slow the rate of premium growth if a carrier has surplus that is at or near its cap.

- **Unintended Consequences:** A carrier may react to the cap by draining surplus in ways that do not involve rate relief. The carrier might increase spending on such things as infrastructure improvements (e.g., electronic medical records) to improve customer service and efficiency. Or, the carrier could make voluntary community benefit outlays, though doing so may run counter to the carrier's self-interest in building market share and improving performance and may encounter resistance from policy holders. The carrier could also increase salaries and bonuses for carrier executives. In addition to uncertain benefits, there may also be adverse consequences of capping carriers' surpluses. First, the intervention could create market instability if premiums are set artificially low. Depending on the scale of the impact on premium rates, some competitors might be forced to exit the market, leaving consumers fewer choices. Second, the short-term savings could be followed later by pricing spikes. Third, having less surplus is likely to cause a health carrier to obtain a lower credit rating from the independent rating agencies, forcing the carrier to pay higher interest costs whenever it needs to borrow money.

Rate Regulation, and Increasing Regulatory Authority and Oversight

- **Key Issues:** Traditionally, state insurance departments have attempted to influence premium levels in a number of ways, including: underwriting and rate-making rules, especially in the small-group and individual segments; rate filing and approval processes; and setting minimum medical loss ratios as is currently in effect in the Washington individual market (as described in Section IV of this report).
- **Advantage:** These types of regulation focus on carriers' ability to generate earnings, rather than on how much surplus carriers keep once surplus is earned. Because these approaches affect the rate-making process, they have a more direct and predictable impact on premium affordability than does capping surplus levels. In this way, states address health care affordability by providing their Insurance Commissioners with the regulatory authority and oversight to monitor and evaluate health carrier surplus accumulation in light of premium growth.
- **Unintended Consequences:** Any type of rate regulation must consider carrier solvency and the importance of regulating carriers on a level playing field. It is also important for the Commissioner to consider in-depth market analysis and review, such as the market review in this report, in any type of rate regulation review and approval process. Further, any type of regulation that interferes *excessively* with traditional market forces and market pricing can have the unintended consequence of forcing carriers out of the market, which is analogous to what occurred in the Washington individual market prior to 2000.

Transparency

- **Key Issues:** Focusing on transparency in health carrier financials, as well as cost and quality of health care services is a means of bringing long-term improvement to the healthcare system. Currently, state law prevents the publishing of RBC levels of health carriers for public access. Rather, RBC is solely for use by the Commissioner in monitoring the solvency of carriers and the need for possible corrective action with

respect to carriers. However, the OIC currently publishes on its website other carrier financial information.

- **Advantage:** Publishing RBC levels of carriers would allow for greater understanding of health carrier surplus levels within the framework of the NAIC minimum level and the BCBSA early warning level. Further, if the Commissioner gains the regulatory authority to conduct carrier rate review and approval, and uses carrier surplus as a factor in this process, RBC publication could also provide greater disclosure to the public with regard to the Commissioner's review and approval process. In addition, increased transparency of existing carrier financial information through in-depth market analysis and review, similar to the type of market review in this report, will also provide stronger public understanding of carrier operations and such additional public scrutiny may push carriers to improve efficiency and carrier operations.
- **Unintended Consequences:** Any regulatory action to improve transparency amongst health carriers must not impose excessive reporting requirements. Otherwise, the goal of transparency will have the unintended consequence of increasing administrative costs and reducing health carrier efficiency.

Community Benefit Requirements

- **Key Issues:** Restructuring a non-profit's Board can push a non-profit carrier to focus more strongly on improving access, premium affordability and other community benefits. Other states have chosen different mechanisms to focus on these issues. While Massachusetts has created formal community benefit guidelines for non-profit HMOs in the state, Pennsylvania formalized the prospective "community activities" of its four Blue Cross Blue Shield Plans and the plans *voluntarily* agreed to commit $150 million annually to a six-year community health reinvestment program after considerable public hearings on these issues. Similarly, CareFirst Blue Cross Blue Shield announced a $92 million initiative intended to address community benefit. This was in response to increased public scrutiny and public hearings.
- **Advantage:** As with the Pennsylvania Blues plans and CareFirst, public hearings on the issues of community benefit and premium rate reductions can push plans to voluntarily reduce premiums and implement community benefit initiatives so that health plan solvency is not jeopardized.
- **Unintended Consequences:** Imposing community benefit requirements on non-profit carriers often serves as an indirect tax on carrier members, who subsidize community benefit initiatives of the carrier with their premiums. Some members prefer a reduction in premiums instead of using premium profits for community benefit initiatives, which serve the community as a whole.

These alternatives have been considered and/or tried in several states, with varying outcomes.

Framework for Next Steps

There are a myriad of ways to regulate surplus, each with potentially unintended consequences. Focusing on increased transparency can improve competition and efficiency while stronger regulatory authority and oversight can provide the first step in addressing concerns of surplus

accumulation. The next step could also be some form of regulatory action such as rate regulation or implementing guidelines on non-profit carrier community benefit requirements. However, neither can be implemented in a vacuum.

We believe the OIC should examine the surplus levels of at least the three largest Washington carriers: Regence, Premera and GHC to assess whether they are appropriate to meet current and future business and risk management needs. Further, this examination of surplus levels should consider Washington-specific market issues, the unique business conditions and requirements of the health carriers, and any policy objectives to increase affordability of coverage. The outcome from this review would likely be the identification of appropriate surplus ranges for each carrier, rather than specific target surplus levels.

Targeting appropriate surplus levels is critical for managing financial risk. It is even more important for non-profit organizations that do not have access to equity markets and must fund investments in new products and infrastructure out of operating results, surplus or debt instruments. Surplus levels which are held too low expose the organization to risk of failure during predictable periods of downturns in the underwriting cycle. They also limit the organization's ability to respond to changes in business conditions and demands for new products. Surplus levels which are too high may affect product affordability and subject the organization to unwanted regulatory scrutiny. Since most states do not impose maximum surplus levels, it is incumbent on state insurance departments to review these issues in light of the context and critical considerations for conducting a surplus review discussed throughout this report.

This issue potentially takes on added urgency in the face of any regulatory action of the Commissioner in the upcoming legislative session (such as draft bill Z-0152 which would provide the Commissioner with explicit authority to consider carrier surplus when reviewing rates) as such action could significantly affect surplus levels. As is the case with any new regulatory action, new requirements could create new financial risks and increase uncertainty around surplus demand. To avoid any regulatory action having the unintended consequence of reducing surplus of carriers that are undercapitalized, we suggest conducting a review of target surplus ranges.

I. INTRODUCTION

The Washington State Office of the Insurance Commissioner (OIC) commissioned The Lewin Group (Lewin) to develop methods to assess whether Washington's domestic carriers have "excess surplus" and if so, how the term could be defined and how any "excess surplus" held by a domestic carrier could be regulated, including whether a single standard should be applied to all licensees. The specific activities undertaken as part of this review included:

- Address whether there are any business conditions or regulatory requirements which are unique to Washington and which would suggest the need to maintain either higher or lower surplus levels;
- Make suggestions about methods to determine target surplus ranges by providing a framework of different methodologies that could be used to model Washington's

domestic for-profit and non-profit carriers surplus (provided to the OIC in a separate document);

- Review the experiences of other states to understand how they have responded to rising surplus levels and to identify viable policy alternatives for consideration; and
- Develop feasible approaches to set limits or guidelines for surplus accumulation.

Lewin conducted a broad-based, general review of the Washington market and Washington domestic carriers, focusing primarily on four (4) large, Washington health carriers: Regence BlueShield (Regence), Premera Blue Cross (Premera), Group Health Cooperative (GHC) and PacifiCare of Washington (PacifiCare). The report does not include an analysis of these carriers' affiliates except where noted. Further, the project did not involve the actual modeling of target surplus ranges for Washington domestic carriers.

A. Background

The major categories of risk addressed by surplus are underwriting risk, portfolio risk, business risk, and the risk of catastrophic events. For each of these risks, each health carrier studied faces special challenges engendered by its situation beyond those risks common to all companies offering health coverage in the United States and to regional health carriers.

The Washington health insurance market is a highly concentrated market creating an environment for carriers that may be of greater risk relative to other states. In order to categorize and better understand the different sources of risk for each specific health carrier studied, it is useful to view these insurance risks along a continuum, ranging from the risks faced by any carrier in the United States to risks facing a specific health carrier. The four levels of this continuum are described below.

Risks for All Insurers

There are risks inherent in providing insurance common to all carriers offering coverage in the United States. Carriers face both general business risks and risks of underwriting.

Business and underwriting risks include:

- Medical price inflation;
- New technologies;
- Pricing accuracy;
- Changing utilization patterns;
- Presence and power of competitors;
- Capital adequacy, which is different for non-profits versus for-profits (as discussed in Section II of this report);
- Growth strategies, measured through membership and revenue;
- Regulatory mandates and price controls;
- Administrative expense management;

- Litigation and other catastrophic events;
- The carrier's mix of business;
- Market concentration and density;
- Reputation in the marketplace, and relationships with brokers and customers;
- Provider reimbursement rates, density and comprehensiveness of provider network, degree of risk sharing with providers, and strength of the carrier's relationships with providers; and
- Reinsurance programs and whether retained risk is commensurate with capital level.

Each carrier is subject to varying levels of risk from exposure to each of these business issues, based on its unique business circumstances.

Risks Related to Operating in a Single Region

Underwriting risk is the largest risk that health carriers face, and regional carriers are more at risk than national carriers in this regard. Regional carriers compete against large national carriers, which have the ability to absorb excessive claims costs that may occur in a single region, such as a natural disaster or a localized epidemic.

Furthermore, national carriers often have a greater ability to maintain and develop technological, actuarial, and financial resources due to economies of scale that are beyond the reach of a localized carrier. This increases the likelihood that they will identify and adapt to emerging trends quickly.

Further, unlike regional carriers, national carriers can also reduce, or even terminate, their participation in the region should market conditions deteriorate sufficiently. National carriers may also be able to identify centers of excellence for treatment of serious and unusual conditions with better outcomes and efficiencies, while regional carriers will be more likely to be constrained to using local providers.

Finally, national carriers also are able to spread administrative costs across a larger base and use their larger size as leverage in contracting. Smaller, regional carriers typically do not have these abilities.

Risks Related to Operating in Washington State

Health carriers in Washington face an environment with certain regulatory requirements in some market segments as well as a high number of benefit mandates.[1] These requirements, as well as the ongoing uncertainty of future regulatory action, limit carrier flexibility and increase financial risks.

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[1] The Washington health insurance market has a relatively high number of mandates which is one indicator of the level of legislative activism by the state legislature that leads to greater uncertainty for WA carriers of future health carrier requirements. Washington currently has 48 health insurance mandates: 23 benefit mandates, 19 provider mandates and 6 eligibility mandates. Only 8 states have 48 or more health insurance mandates; only 18 states have 23 or more benefit mandates; only 4 states have 19 or more provider mandates and 28 states have 6 or more eligibility mandates. Health Insurance Mandates in the States: 2005, Council for Affordable Health Insurance, (January 2005). For more up-to-date information regarding Washington's health insurance mandates, please see: Mandated Provisions – Washington State, Updated (Oct. 19, 2006).

Plan-Specific Risks

Each health carrier carries certain risks related to each carrier's provider reimbursement rates and payment, mix of business, asset investment, density of provider network, local market conditions and amount of counter party risk (ASO business)[2] and access to capital.

In evaluating appropriate surplus levels, each of the risk categories noted above should be considered and fully evaluated with a clear focus on the unique circumstances of each carrier, recognizing that an adequate level of surplus for one carrier may not be adequate for another carrier based on differences in their business risks.

B. Development of this Report

Lewin's task consisted of qualitative and quantitative information gathering and expert analysis on the subject of measuring appropriate surplus levels and accumulation for Washington domestic carriers, focusing on the four larger carriers: Regence, Premera, GHC and PacifiCare. Our major activities included:

- In-depth interviews with each health carrier's executives representing the financial planning and actuarial departments, government affairs, and marketing. These interviews provided information on each carrier's market position relative to competitors, as well as the ways in which Washington's market differs from other states. We also took into account regional and national market trends that may affect each carrier.
- Interviews with Washington advocates to gain the consumer perspective on these issues, including Washington-specific health insurance affordability concerns.
- Primary and secondary source research on laws, regulations, and practices governing (a) the accumulation of surplus and (b) the regulation of the Washington health insurance market.
- Assessment of Washington's health insurance market with particular attention to business risks, insurance risks, and the competitive nature of the market.
- Assessment of each carrier's financial performance.
- Interviews with OIC staff and other state regulators to garner information on the policy implications and options for regulatory action as well as potential unintended consequences of proposed regulatory action.

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[2] Administrative Services Only (ASO) is a type of contract with an insurance company or a third-party administrator that provides an employer with administrative health services. It does not provide coverage for risk of insurance protection (insured business). The usual services covered under ASO business include claims processing, carrier design advice and printing benefit booklets. These contracts are usually entered into by large employers who can afford the risk of providing insurance protection with their own money. National Association of Health Underwriters, Consumer Information, Glossary of Terms, *available at* http://www.nahu.org/consumer/glossary.cfm.

The scope of the project did not involve the actual modeling of target surplus ranges for Washington domestic carriers. Thus, Lewin did not assess the sufficiency of each carrier's specific surplus levels.

C. Report Organization

After providing some background information on measuring surplus and laws and regulations related to surplus in Sections II and III respectively, the main body of this report is divided into two remaining sections. First we discuss the insurance market in Washington, including both the regulatory and competitive market environments. We then provide a framework of policy options to assist the OIC in addressing surplus accumulation as well as examples of regulatory action the OIC could take and the unintended consequences of implementing such options.

II. SURPLUS AND RELATED FINANCIAL MEASURES

Reserves and surplus are important and distinct terms that are sometimes mistakenly used interchangeably. Risk-based capital, or RBC, is a measure adopted by the National Association of Insurance Commissioners for use in assessing surplus adequacy. To ensure clarity in the discussion and analysis provided in this report, the terms are defined below.

A. Reserves and Surplus

Claims reserve, often shortened to **"reserves,"** is a term for the estimate of the amount of money that a health care carrier needs in order to pay health care providers for services that members have used but for which claims have yet to be submitted and/or processed and paid, to make retroactive cost adjustments to providers, and to build specific case reserves for high-cost medical cases or for legal costs for cases with unpaid claims.

On a carrier's balance sheet, claims reserves have liability characteristics which are the foreseeable debt owed to health care providers who are currently caring for carrier members. The reserves a carrier holds do not represent disposable funds because there is a directly offsetting liability.

Premium reserves includes premium deficiency reserves and gross premium valuation reserves. Both are intended to offset predictable premium losses for specific products. **Operating reserves** includes ordinary operating reserves for specific, known liabilities (e.g., taxes, payables, etc.). This report does not assess reserves.

Reinsurance or stop loss coverage is secondary insurance purchased by the carrier to offset potential, extreme losses related to medical claims.

Surplus, or unallocated reserves, in contrast, represents a carrier's retained earnings or funds on hand for which there is no corresponding liability on the company's balance sheet and which the carrier uses during adverse business conditions and to support investment needs. In other contexts, surplus would be interchangeable with such terms as "retained earnings," which is typically used in non-profit organizations such as hospitals, or "net worth," which is common in for-profit companies.

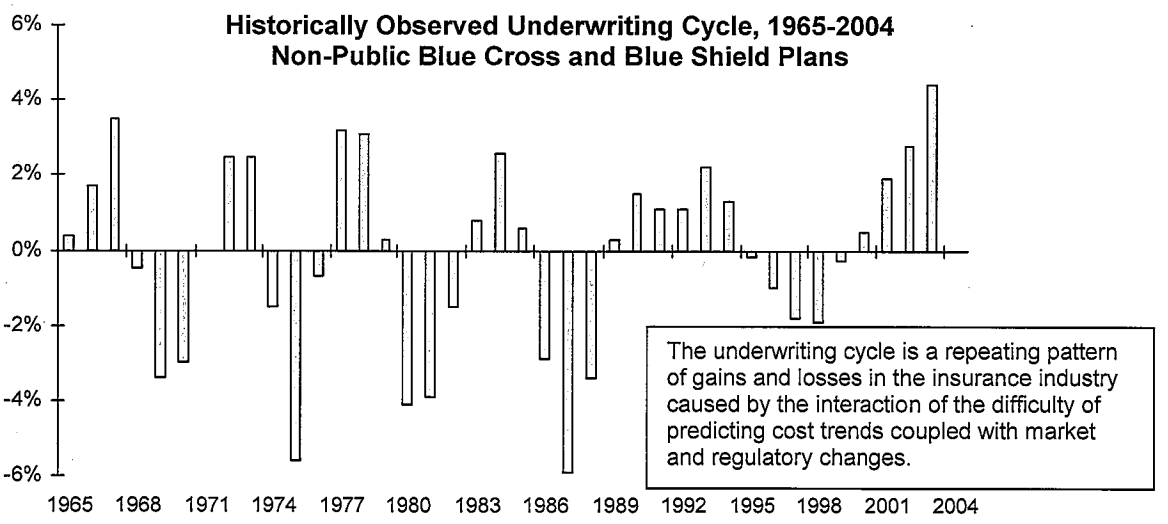
How is surplus measured?

Regulators can measure surplus adequacy in several ways, including months of premium, risk-based capital (RBC) ratio, and surplus as a percent of revenue (SAPOR). SAPOR measures capital and surplus as a percentage of insured premium revenue net of reinsurance ("total revenues").

Why is surplus needed?

Surplus provides the underpinnings to allow carriers to withstand sustained periods of adverse financial results. Surplus is intended to serve as a cushion against adverse circumstances, reduce financial risk and serve as a capital resource. Adverse circumstances include unplanned medical expenses, declining enrollment, inadequate premiums to cover medical expenses, adverse selection risks, financial exposure associated with new mandates and regulatory controls and investment risks. For instance, carriers are generally not able to immediately respond to adverse conditions arising from pricing or cost management inflexibility. This is especially the case since most carriers provide a 12-month rate guarantee. Further, carriers may also have limited pricing flexibility due to regulatory limits.

Finally, surplus also allows companies to make needed investments in infrastructure and technology to serve their customers more efficiently and effectively. Thus, surplus ensures the carrier's solvency and ability to meet long-term contractual obligations and business needs. An example of how underwriting cycles drive surplus demand is shown in the graph below. Health carriers must target surplus levels which will sustain financial performance during naturally occurring downturns in underwriting cycles.



Source: Phyllis A. Doran, FSA, Robert H. Dobson, FSA, and Ronald G. Harris, FSA, "Financial Management of Health Insurance: Forecasting, Monitoring and Analyzing Health Plan Experience," Milliman USA Research Report, December 2001 and based on statutory filings as compiled by Goldman Sachs as of early 2005.

Surplus is often a subject of public policy debate. While inadequate surplus can result in contracted benefits not being paid and a company's insolvency, policymakers or carriers may pursue alternative uses of surplus for purposes such as providing additional benefits for enrollees, additional payments to providers, lower premiums for consumers and capital investments.

In an era of increased concern over the price of health care and the conduct of health carriers, surplus levels are subject to much discussion by insurance regulators and state legislatures across the country. Determining appropriate surplus levels is somewhat subjective, however, requiring not only financial analysis but also judgment and experience, given the complexity of measuring the risk of loss facing a carrier and the unique business characteristics facing each carrier.

What factors drive demand for surplus?

Various business factors drive higher requirements for surplus to provide a financial cushion against potential unanticipated risks as shown in the chart below. For instance, non-profit carriers are often confused as charities that should not hold any surplus. However, these carriers may need higher surplus to offset specific operating constraints. This is because non-profit carriers have less ready access to capital since their primary source of capital is retained earnings. In addition, access to, and costs of, borrowed funds are heavily dependent on financial performance and stability.

In contrast, for-profit carriers tend to retain surplus at lower levels than non-profit carriers. Generally, for-profit health carriers, especially the larger publicly traded firms, find less advantage in having big surpluses. First, these carriers must demonstrate to investors the highest possible return on equity. By converting surpluses to other uses—such as buying back shares—they lower the denominator in the return-on-equity formula and raise the result.

Second, for-profit carriers have access to external equity capital and can sell shares in order to raise cash, while non-profit carriers do not have this option, requiring them to retain sufficient capital for contingencies along a long time horizon.[3] Further, the structure of for-profit carriers is often as holding companies. The entities holding state insurance licenses are wholly owned subsidiaries, and those subsidiaries usually pass their profits up the line quickly. This action creates the appearance of low surplus held by the entity that files reports with state regulators. However, it is important to note that both for-profit and non-profit health carriers have the ability to borrow funds as needed and must comply with the Washington-adopted NAIC surplus minimum levels.

The following chart provides the various business factors that drive higher requirements for surplus and those business factors that drive lower requirements for surplus. The spectrum of surplus ranges is expressed as surplus as a percent of total net revenue (SAPOR), where revenue represents revenue net of reinsurance.

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[3] Sherlock Company, Report to Pennsylvania Insurance Commissioner, Responses to Commentors, (October 6, 2004).

Lower SAPOR	Higher SAPOR
• Reinsurance contracts where risk is ceded to another entity • For-profits – access to capital through stock offerings • Large Plan ➢ Larger population to spread cost/risk, impacted less by enrollment fluctuations ➢ Lower proportion of admin expenses fixed ➢ Economies of scale and cost efficiencies for certain admin functions • Participate in less risky markets • National carrier ➢ Technological, actuarial and financial economies of scale ➢ Can absorb excessive claims costs from a single region natural disaster ➢ Can spread admin costs across a larger (wider) base ➢ May be able to use its larger size as leverage in contracting • Management of care ➢ High cost case management ➢ Disease Mgmt, Care Mgmt programs • Market Intelligence ➢ Longevity of the carrier ➢ Penetration of the market • Historical provider who has a strong understanding of the marketplace	• No reinsurance contracts ceding risk to another entity • Non-profits – only source of capital is retained earnings • Small Plan ➢ Smaller population to spread cost/risk and more heavily impacted by enrollment fluctuations ➢ Higher proportion of admin expenses fixed • Participate in riskier markets ➢ Participate more heavily in the individual and small group markets in which they may be subject to adverse selection ➢ Higher proportion of business in indemnity or less managed products ➢ Government markets (Medicare, Medicaid, where premium rates are established earlier and in some cases, set by others) • Regional carrier - focused in a single geographic region so the carrier cannot spread risk across multiple markets • No Care Management Programs • Market Uncertainties ➢ New product introduction (Medicare Part D) ➢ Expansion into a new region ➢ Entry of a new competitor

What happens if a carrier does not hold enough surplus?

Carrier insolvency affects many stakeholders. For instance, consumers may have to pay for services out-of-pocket, may experience interruption or reduced access of services, may need to change physicians and may experience higher premiums and less product choice given reduced market competition. Similarly, providers and medical suppliers may not get paid, may experience interruption of services and may experience insolvency. The State may suffer a loss in tax revenue, disruption in the insured process and experience an adverse impact on its economic climate. Employers may lose a stable health carrier for employees and may need to cover new health carrier costs despite having paid premiums for a now-insolvent carrier. Finally, carrier employees lose jobs and may lose retirement funds.

Four case studies provide a more detailed understanding of what happens when a carrier does not hold enough surplus:

- **Blue Cross Blue Shield of West Virginia** became the first Blue Cross and Blue Shield plan to be liquidated by a State Insurance Commissioner in 1990, leaving thousands of people and numerous health care providers with millions in unpaid claims for years before outside assistance resolved the situation. The plan was not included in any state guaranty fund and did not have a safety net for subscribers.[4]
- **KPS Health Plans (KPS)** was placed in receivership in August 1999 after failing to meet the statutory requirements for net worth. At the beginning of its receivership, KPS had amassed a deficit of $8 million. Such undercapitalization left the carrier vulnerable to multiple, high-cost claims and other adverse economic impacts. In 2005, the Washington Insurance Commissioner agreed to sell KPS to GHC.[5]
- **HIP Health Plan of New Jersey**, declared insolvent in November 1998 and liquidated in March 1999, left approximately $120 million in unpaid claims to physicians and hospitals. As with BCBS of West Virginia, there was no state guaranty fund at that time to bail out the plan. Approximately 190,000 members were forced to look for new coverage and all state insurance carriers were required to have an open enrollment for HIP enrollees during March 1999.[6]
- **Harvard Pilgrim's Rhode Island subsidiary** was put into receivership by Rhode Island officials in October 1999, ceased operations Dec. 31, 1999, and was liquidated in January 2000. When it ceased operations, the Rhode Island subsidiary was serving 177,000 members. Under the March 2000 agreement between Massachusetts and Rhode Island state officials, HPHC-MA agreed to supplement HPHC-RI's assets with $14.5 million and commit any additional funds necessary to meet HPHC-RI's obligations. Further, HPHC-MA guaranteed payment of any deficiency in funds necessary to satisfy HPHC-RI's member and provider obligations in full and processed HPHC-RI member and provider claims at cost. Members were forced to seek new health plans with only two months notice with approximately 9 percent of patients uninsured at some point following Harvard Pilgrim's closure. More than one-third of patients (35 percent) reported having no choice of health plan when Harvard Pilgrim was closed. Further, more than one-third of staff model providers (38 percent) experienced a period of unemployment, with mental health providers experiencing 56 percent unemployment. [7]

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4 GAO Report, Blue Cross and Blue Shield Experiences of Weak Plans Underscore the Role of Effective State Oversight, April 1994; Letter from BCBSA to Leslie G. Aronovitz, US GAO (Feb. 11, 1994); "Critical Developments in the Blue Cross & Blue Shield System" Session at the Healthcare Financial Management Association Capital Conference, (April 1993).

5 State of Washington Office of the Insurance Commissioner, Questions and Answers, (April 2005), *available at* http://www.insurance.wa.gov/industry/oicactions/kps/QuestionsAnswersPrintable.asp.

6 The Forums Institute, Public Oversight of Managed Health Care Coverage-Consolidation-Costs, April 1999; Linda R. Brewster, Leslie A. Jackson, Cara S. Lesser, "Insolvency and Challenges of Regulating Providers that Bear Risk" Center for Health System Change Issue Brief No. 26, (February 2000).

7 Robert Wood Johnson Foundation, "Measuring the Fallout from Shutdown of a Rhode Island Health Care Organization," (May 2003); Massachusetts Division of Insurance Press Release, "Governors Cellucci, Almond Announce Agreement: Harvard Pilgrim Receiverships in Both States Will Coordinate Efforts," (March 20, 2000); Office of Massachusetts Attorney General Press Releases, (March 20, 2000), (May 24, 2000).

What happens if a carrier holds too much surplus?

Carriers that hold too much surplus affect product affordability and subject the organization to unwanted regulatory scrutiny. Regulators question why these carriers are not returning excess surplus to members through premium reductions and hold carriers accountable for high surplus through rate increase denials. Carriers must then justify the need for such excess surplus and explain their surplus strategy.

Carriers that hold excess surplus may use this excess in many different ways: to retain market presence and dominance, increase salaries and bonuses for carrier executives or for product line and member needs. To improve customer service and efficiency, carriers might increase spending on such things as infrastructure improvements (e.g., electronic medical records). Or, the carrier could reduce rates or make voluntary community benefit outlays, though doing so may run counter to the carrier's self-interest in building market share and improving performance and may encounter resistance from policy holders.

A number of Blue carriers have taken measures in the last few years to reduce their surpluses voluntarily. As an example, after earning high profits in 2003, several Blue carriers refunded millions of dollars of premiums paid by insured groups and individuals. Blue Cross Blue Shield of Rhode Island gave back a total of $21 million to its policyholders and providers, Horizon Blue Cross Blue Shield of New Jersey refunded $55 million, and Blue Cross Blue Shield of Tennessee slowed premium rate increases in 2003, and then returned $67 million to customers at year's end.[8] The windfall in Tennessee was partly driven by changes to hospital contracting arrangements between the plan and a large hospital system that led to large retroactive cost savings. Most recently, the Board of Directors of Blue Cross and Blue Shield of North Dakota (BCBSND) voted to refund more than $26 million to its policyholders. The refunds, which are based on August 2006 premiums, are due to the company's financial surplus that exceeded targeted levels. The company awaits a favorable opinion from the North Dakota Attorney General as to the legality of the refund and regulatory confirmation by the North Dakota Insurance Commissioner. Although not required by law, BCBSND attempts to maintain between three and four months of surplus at all times to maintain financial strength and to help stabilize premium rates for employer groups and to individual members.[9]

Blue plans also have begun to reduce premiums, partly in response to higher surplus levels. Blue Cross Blue Shield of North Carolina used some of its 2003 profits to reduce the rate of increase in premiums for 2004. Rate increases for group customers were five percentage points lower for the first quarter of 2004 than for the same period in 2003. Individual enrollees saw premium increases that were nine percentage points lower.[10] In early 2005, CareFirst Blue Cross Blue Shield (MD, DC, DE, and Northern VA) pledged to slow surplus growth by quoting premium rates 3 percent lower than the expected medical cost trend would suggest. It is expected that this action would trim $60 million, or about one-third of its 2004 operating

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[8] "Some Blues' Premium Givebacks Generate Sales, Goodwill, While Others Get Criticized," The AIS Report on Blue Cross and Blue Shield Plans, (February 2004).

[9] "BCBSND to Refund More Than $26 Million to Policyholders," BlueCross BlueShield of North Dakota, Newsroom, (September 2006), *available at* https://www.bcbsnd.com/newsroom.

[10] "Not-for-Profit Blues' Strong 2003 Financial Results Could Invite Regulatory Scrutiny," The AIS Report on Blue Cross and Blue Shield Plans, (March 2004).

income, from CareFirst's 2005 results.[11] Finally, Regence implemented rate decreases in its Small Group and Individual lines effective July 1, 2006 given the carrier's strong surplus position.

B. Risk-Based Capital (RBC)

Risk-based capital (RBC) is a measure used to establish the minimum amount of capital appropriate for a health organization to support its overall business operations during a period of adverse conditions. RBC considers the size, structure and risk profile of the carrier. When comparing the surplus of different carriers such as HMOs[12], health care service contractors (HCSCs)[13] and life and disability carriers[14], RBC is an effective measure of comparison given that it takes into account the differences in each carrier's licensure and operation.

RBC was introduced as a concept by insurance industry regulators to refine the definition of surplus requirements of carriers taking into account the nature of the risks that different companies face, as well as varying degrees of volatility that arise with alternative sets of risks.

> *RBC is an approach to determining the minimum level of capital cushion needed for protection from insolvency, based on an organization's size, structure, and retained risk. Factors in the RBC formula are applied to assets, premium, and expense items. The factors vary depending on the level of risk related to each item. The higher the risk related to the item, the higher the factor, and vice versa.*[15]

The National Association of Insurance Commissioners (NAIC) set forth a standard formula for the computation of RBC, taking into account the risk characteristics of a carrier's investments and products. The RBC of any carrier is unique to that carrier, because no two carriers have exactly the same mix of assets and risks. The NAIC also created a model RBC law (RBC Model Act) for states to adopt for the purpose of regulating health carriers' minimum surplus levels. The RBC Model Act establishes the formula for calculating the RBC requirements. The law requires increasing regulatory oversight and intervention as a carrier's RBC declines. The level of regulatory oversight ranges from requiring the carrier to inform and obtain approval from

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11 "CareFirst Premium Cuts Seen as Step Toward Not-for-Profit Mission," The AIS Report on Blue Cross and Blue Shield Plans, (February 2005).

12 Washington State defines an HMO as any organization "which provides comprehensive health care services to enrolled participants of the organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for co-payments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization." RCW § 48.46.020.

13 An HCSC in Washington State is defined as "any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services." RCW § 48.44.010.

14 A life and disability insurer means any insurance company authorized to write only life insurance, disability insurance, or both, as defined in chapter 48.11 RCW. Washington state statute defines "disability insurance" as "insurance against bodily injury, disablement or death by accident, against disablement resulting from sickness, and every insurance appertaining thereto including stop loss insurance" which is insurance against the risk of economic loss assumed under a self-funded employee disability benefit plan. RCW §§ 48.05.430, 48.11.030.

15 Audrey Halvorson and Craig Keizur, "Risk-Based Capital Requirements for Managed Care Organizations," Milliman & Robertson, Inc. Research Report, (December 1998).

the state Insurance Commissioner of a comprehensive financial plan for increasing its RBC to mandatory regulatory intervention requiring the Commissioner to place a carrier under regulatory control in rehabilitation or liquidation proceeding. Washington is one of the many states that have adopted the NAIC's RBC Model Act.

The NAIC's RBC formula was not originally developed with health insurance in mind but was later modified for health insurance in recognition of the complicated nature of this particular insurance market. Health insurance has special characteristics that make successful competition more capital intensive than in a traditional insurance setting. Health insurance is technologically complex. Carriers must maintain claims payment systems, produce frequent member communications, keep data repositories for analysis, reporting, and audit, and attract and retain employees of sufficient talent to use the data effectively. In addition, care and disease management functions are now a routine and expected part of the services provided by health carriers. This requires clinical management expertise and continuous monitoring of best practice developments to keep up with new medical technologies. All of these activities related to health coverage have significant capital requirements, including constant upgrades and training to keep up with emerging technologies.

In addition, since health insurance is very competitive and typically produces relatively small margins, full recovery from any long period of substantial downturns takes a long period of time, even for a very well-managed carrier. Surplus provides the source of capital to recover from adverse experience, as well as resources to invest in the company's business to maintain competitive service levels and meet changing customer needs.

III. LAWS AND REGULATIONS RELATED TO SURPLUS

There are various mechanisms that regulate health carriers' surplus levels. Some mechanisms include state laws, and internal carrier actions. Blue Cross Blue Shield carriers are also subject to oversight by the Blue Cross Blue Shield Association. This section provides background as to how surplus is regulated.

A. Surplus Oversight

1. NAIC Model

Most states, like Washington, have enacted variations of the NAIC Model Health Risk-Based Capital (RBC) Act to regulate surplus minimums. The Act establishes clear, consistent guidelines for the calculation of RBC and identifies trigger points for regulatory intervention. As shown below, Washington has adopted the NAIC trigger points for intervention based on the NAIC risk-based formula.

NAIC Trigger Points for Intervention Based on Risk-Based Capital Formula

RBC Level	Company or Regulator Response
Company Action Level (200% ACL)	Under WA law, the company must submit an RBC plan to the Commissioner. This plan includes, among other things, proposals of corrective actions it will take.
Regulatory Action Level (150% ACL)	The company must submit a corrective plan of action to remedy the situation or where applicable, a revised RBC plan. After examining the company's plan, the Commissioner will issue an order specifying the corrective actions needed.
Authorized Control Level (ACL)	The Commissioner is authorized to take regulatory action as may be necessary to protect the interests of the policyholders, including placing the company under regulatory control.
Mandatory Control Level (70% ACL)	The Commissioner is required to place the company under regulatory control.

Source: RCW §§ 48.05.430, 48.05.440

2. Oversight of Surplus by the National Blue Cross Blue Shield Association

The Blue Cross Blue Shield Association (BCBSA) licenses member carriers to use the Blue Cross and Blue Shield brand names and trademarks and requires that carriers meet specific standards for financial performance. As Blue Cross Blue Shield carriers, Regence and Premera adhere to the BCBSA licensure requirements. BCBSA sets higher standards for RBC ratios than NAIC, for three reasons: 1) to uphold the strength of the Blue brand; 2) to avoid the potential for joint and several liability of Blue carriers; and 3) to assure an early warning if a carrier is in danger of becoming inadequately capitalized, so that it may intervene before regulators have to. These BCBSA standards are as follows:

- **Termination of Blues license at 200% RBC.** The Association can terminate a carrier's right to use the Blues brand if the carrier's RBC falls below the 200% level, which NAIC refers to as the Company Action Level.
- **Association Intervention triggered at 375% RBC.** After performing a statistical analysis of the historical volatility of surplus levels for Blue carriers, BCBSA's actuaries determined that the benchmark for Association intervention should be an RBC ratio of 375%. If a Blue carrier's surplus falls below this level, it is subject to additional reporting requirements by the Association. According to the actuaries' analysis, this gives the Association sufficient warning before a company's surplus is likely to decline to the 200% level.

The Blue Cross Blue Shield Association also requires Blue carriers to either participate in a state guaranty fund, establish an alternative method to ensure payment of claims liabilities and continuation of coverage in the event of insolvency, or have 800% or greater of the Authorized Control Level RBC.[16] Washington State does not have a guaranty fund for health care service contractors (HCSCs). We note that both Regence and Premera are HCSCs and are members of

[16] Highmark Blue Cross Blue Shield, Letter to Pennsylvania Insurance Department, (November 8, 2004).

the Association. However, the state does have a "hold harmless" requirement where providers are required, as part of their contracts with carriers, in the event of solvency problems, to continue to care for a carrier's members for the duration of the period for which premiums have been paid to the carrier or until the person covered is discharged from inpatient facilities, whichever time is greater.[17] Regence and Premera participate in this contract arrangement, as well as maintain RBC levels sufficient to meet BCBSA requirements.

It is important to note that BCBSA has not established a maximum surplus standard for Blue carriers. It is at the discretion of each Blue carrier's management to determine the appropriate level of capital and surplus, based on its assessment of the future needs and uses of capital in its business, taking into consideration both company and marketplace trends and future contingencies. BCBSA, like the NAIC, adheres to the position that the risk-based capital formula is applicable only for the purpose of detecting whether a carrier is approaching insolvency.

B. Washington State Laws and Practices

A majority of the states, like Washington, have adopted the NAIC's Model Health Organization Risk-Based Capital Act. State laws concerning reserves and surpluses and Insurance Commissioners' uses of their authority aim to ensure that sufficient capital is available to health carriers in order to weather adverse events and protect consumers. However, very little state regulation exists to limit the amount of reserves and surpluses that health carriers can accumulate.

In Washington, *a health care service contractor* (such as Regence, Premera and PacifiCare) must have and maintain a minimum net worth equal to the greater of three million dollars ($3,000,000) or two percent of annual premium earned as reported on the most recent annual financial statement filed with the Commissioner on the first one hundred fifty million dollars ($150,000,000) of premium and one percent of the annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000).[18]

Similarly, a Washington *health maintenance organization* (such as GHC and Molina) must have and maintain a minimum net worth equal to the greater of three million dollars ($3,000,000) or two percent of annual premium earned as reported on the most recent annual financial statement filed with the Commissioner on the first one hundred fifty million dollars ($150,000,000) of premium and one percent of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000) or an amount equal to the sum of three months' uncovered expenditures as reported on the most recent financial statement filed with the Commissioner.[19]

C. Target Surplus Levels

The level of surplus required to provide an adequate margin of safety is a matter of judgment, and experts do not agree on a "correct" target surplus level for a health carrier. The NAIC, as

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17 WAC § 284-43-320.

18 RCW § 48.44.037.

19 RCW § 48.46.235.

one interested party, only addresses the minimums needed to ensure solvency, and further asserts that RBC is not an appropriate tool to use at higher levels of surplus.

Surplus represents the financial cushion that a carrier needs to safeguard against unanticipated circumstances that could cause extraordinary losses. But protecting against catastrophe is only part of the picture. Even under normal conditions, it is very difficult to predict health care costs accurately, and it is especially difficult to do so consistently. Moreover, competition leads health carriers to quote premiums that provide only a narrow margin for error, so that a small under-estimation (in percentage terms) of health costs can swing the carrier's underwriting results from a modest gain to a big loss.

Thus, some cushion is necessary just to protect a carrier from the ordinary vagaries of the health care and health insurance markets. It is in the public's interest to protect both carrier members and the broader community from the undesirable consequences of a carrier's insolvency. Beyond protecting against adverse claims experience, carriers also require capital for competitive, service, and regulatory response purposes. Insurers contend that a carrier wants to provide an adequate margin of safety so that the company can endure periods of adverse experience without triggering any form of regulatory intervention. Thus, the "right" level is carrier-specific; it is not a single number applicable to all carriers.

D. How Do Other States Regulate Maximum Surplus?

Given the increasing lack of affordability of health care due to rising health care costs, there has been increasing interest in capping surplus. However, while most states have adopted the NAIC minimum surplus requirements, few states have chosen to regulate the upper bounds of surplus accumulation.

- **Pennsylvania** set upper limits on surplus on all four of its Blue plans (950% RBC for Blue Cross of NEPA and Capital Blue Cross; 750% for Highmark and Independence Blue Cross). Currently none of the Pennsylvania Blue plans holds surplus in excess of these upper limits. If a plan did exceed the surplus upper limit, the plan would have to file a report with the Pennsylvania Insurance Commissioner justifying its current surplus level or file a plan explaining how it will divest its surplus in a manner that will benefit its policyholders.[20]

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[20] The Pennsylvania Legislative Budget and Finance Committee commissioned Lewin to conduct a study of the regulation and disposition of reserves and surpluses of the four Blue plans. Lewin found that the upper limits on surplus were reasonable. The Lewin Group, Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans, prepared for The Pennsylvania General Assembly Legislative Budget and Finance Committee (June 13, 2005), available at *available at*http://www.lewin.com/NR/rdonlyres/E38A1263-0410-4E37-A300-4A1A4AC4EF3B/0/3192.pdf. Interestingly, the Pennsylvania Supreme Court recently revived a lawsuit filed five years ago by the owner of a Bensalem appliance store, who wants Independence Blue Cross to return part of the surplus to insurance buyers. On Nov. 22, 2006 the Pennsylvania Supreme Court reversed a December 2002 Commonwealth Court decision dismissing the case. The class-action lawsuit will now go back to the lower courts along with three similar ones, each against one of the state's four Blue Cross and Blue Shield health plans. The cases have yet to address whether the surpluses are excessive and who has authority to determine whether the Blues breached their obligations as nonprofits by holding too much surplus and not using such surplus to lower premiums or help the uninsured. Both the Blues and the Insurance Department in Pennsylvania argue that the size of the surplus is a regulatory matter for the state Insurance Department. Von Bergen, Jane M. "Blues Again Face Suit over Surplus [Pennsylvania]" *The Philadelphia Inquirer* (November 30, 2006).

- **Michigan** has capped Blue Cross Blue Shield of Michigan's surplus at an RBC ratio of 1000%. If the cap is reached, BCBSM must file a plan for approval by the Commissioner to adjust its surplus to a level below the allowable maximum surplus. The Commissioner can formulate an alternate plan if the Commissioner disapproves of the plan filed.
- **Hawaii** law required that if a non-profit health plan's net worth exceeds 50% of its annual health care expenditures and operating expenses, as reported on the plan's most recent financial statement filed with the Commissioner, then the excess money had to be either returned to the enrollees of the plan or be applied to stabilize or reduce rates or charges payable by the enrollees of the plan. This statute had a sunset date of June 30, 2006 and was not renewed at that time due to health plan opposition.[21]
- **New Hampshire** caps a non-profit health carrier's contingency reserve funds at 20% of annual premium incomes. However, the law is moot since the New Hampshire BCBS plan, which was the state's only non-profit plan, is now a for-profit. Prior to this conversion, the state chose not to enforce the limit.

IV. WASHINGTON'S REGULATORY AND MARKET ENVIRONMENT

This section provides an overview of Washington's regulatory and market environment. In addition to considering the requirements associated with measuring and establishing appropriate surplus ranges noted in the sections above, it is also critically important to understand the unique market circumstances in which a carrier operates and the potential impact that market may have on each carrier's risk. Each state regulates the insurance market differently and each market has evolved in very unique ways. Therefore, any framework for evaluating Washington carriers should include a review of the unique characteristics and requirements of the Washington market (both regulatory and competitive).

A. Regulatory Overview

The main sources of health insurance coverage in Washington mirror national trends. However, as the chart indicates below, Washington's population reflects a slightly lower proportion of uninsured individuals and Medicare beneficiaries than nationally.[22]

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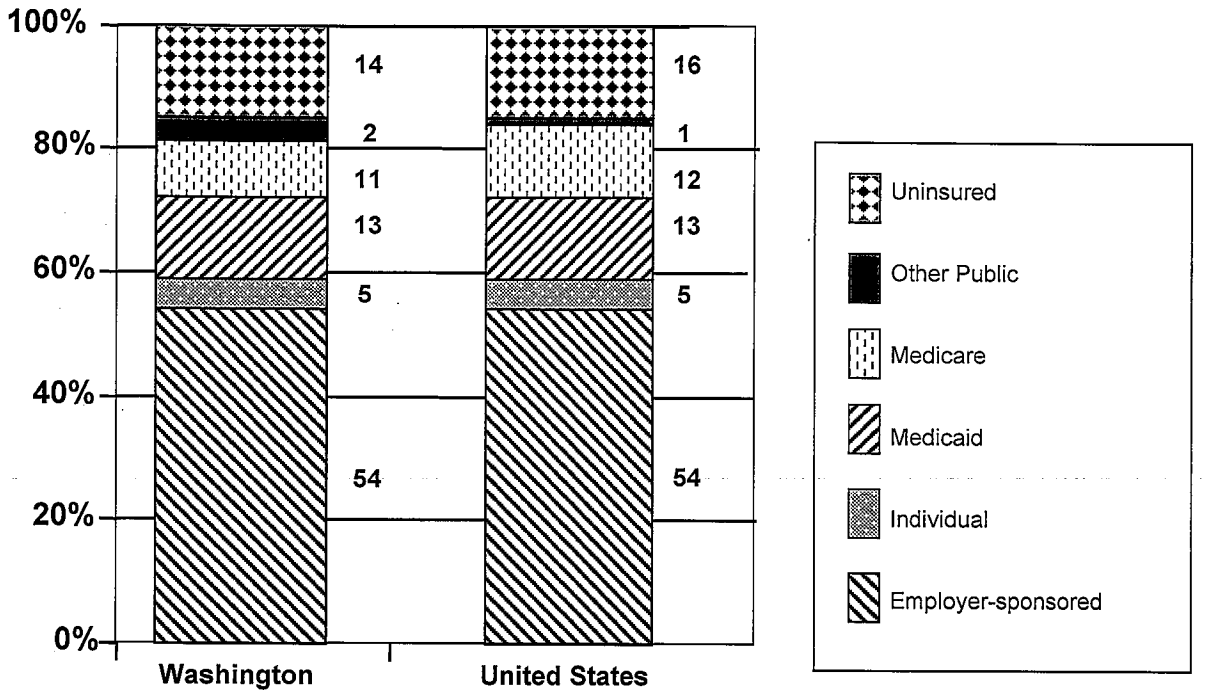
[21] Haw. Rev. Stat. §§ 431:14F-101, 431:14F-106 (repealed), *available at* http://www.capitol.hawaii.gov/hrscurrent/Vol09_Ch0431-0435E/HRS0431/HRS_0431-0014F-0106.HTM; Lim, Lloyd, Administrator of Health Insurance Branch, Insurance Division, Hawaii Department of Commerce and Consumer Affairs. Phone interview. (November 2, 2006).

[22] It is important to note that the number of uninsured Washington residents has risen from 703,965 in 2002 to 748,460 in 2004. The amount this care costs the Washington health care system and public has also increased from $457 million to $553 million in the same time period "New Report Reveals Cost of the Uninsured Rises to More than $550 Million," OIC News Release (Sept. 7, 2006).

Population Distribution by Primary Insurance Source



Source: State Data 2003-2004; U.S. data 2004; Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey *available at* http://www.statecoverage.net/profiles/washington.htm

Further, Washington's health insurance market is highly concentrated. Washington lacks strong market competition with three large domiciled health carriers holding the majority of the market share.

Additionally, health carriers in Washington face certain regulatory requirements in some market segments, including the individual and small group markets. These requirements limit carrier flexibility and increase risks. For example, State lawmakers passed legislation that require carriers to rate individual products up to 72% Medical Loss Ratio or MLR (MLR is medical claims expense divided by premium income). If a carrier's MLR is less than 72%, then the carrier is required to remit the difference between the actual MLR and a MLR at 72% to the Washington State Health Insurance Pool (WSHIP), the state's high risk pool.[23]

Further, Washington has an adjusted community rating in the small group market which means that carriers can adjust premiums charged for only age or other specified factors.[24] Each health carrier within the state that offers small group plans must develop its rates based on an adjusted community rate and may only vary the adjusted community rate for geographic area, family

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[23] David Peel, "Have We Mastered the Underwriting Cycle?" Washington Healthcare News, (November 2006); *See* RCW 48.20.025(6) (disability carriers), 48.44.017(6) (HCSCs), and 48.46.062 (6) (HMOs).

[24] Kaiser Family Foundation, State Health Facts, Small Group Health Insurance Market Guaranteed Issue (2005). Factors are listed at: RCW 48.44.023 (HCSC), RCW 48.46.064; and RCW 48.21.045(3) (disability carriers).

size, age, and wellness activities.[25] In many states, premiums for small group health insurance can vary based on health status. In Washington, health status cannot be used as a rating factor.

Medicaid, Basic Health and Medicare: Risks Related to Participating in Government Markets

There are both advantages and disadvantages for a health carrier to participate in government markets. While these markets offer a large pool of beneficiaries and represent a disproportionately large share of total health care spending, they are also constrained by the inflexibility inherent in heavily regulated markets. Earnings from government sources are more vulnerable than those of commercial segments because the government imposes controls over premium levels and precludes a company's ability to control pricing fully or affect selection through benefit redesign. Therefore, when operating and pricing in government markets, health carriers are less able to react to and meet market demands. Plans that participate heavily in government markets benefit from their large populations and revenue stream, but bear more risk from the stiff premium constraints and less flexible benefit design inherent in these programs.

Medicaid and Basic Health

The State of Washington's Medicaid managed care program contracts with Molina Healthcare, Community Health Plan of Washington, Regence, GHC, Columbia United Providers and Assuris, a Regence affiliate. Molina Healthcare has the largest enrollment at 53.7% of the market, while Community Health Plan of Washington has an enrollment of 28.4% of the market. Regence has an enrollment of 7.4% of the market, while the remaining three health plans have a combined enrollment of 10.4% of the market (Enrollment as of December 2005).[26]

Key areas of risk for carriers in the Medicaid managed care market include:

- Insufficient capitation rates;
- Lack of federal and state regulation over solvency in considering rates or rate adequacy;
- Anti-selection;
- Changes in enrollment procedures, eligibility determination processes, benefits, or other changes to the structure of the program; and
- Expansion to new populations.

Similar risks exist for Washington's Basic Health market. Washington's Basic Health plan was created in 1988 in order to provide health care coverage to those Washington residents with family incomes at or below 200 percent FPL. As a state-subsidized health plan for low-income residents, Basic Health works in conjunction with Medicaid to provide coverage to a whole

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[25] RCW §§ 48.21.045, 48.43.005.

[26] AIS Directory of Health Plans (2006).

family unit, many times enrolling children in Medicaid (Basic Health Plus) and their parents in Basic Health.[27]

Medicare

Currently, Regence and GHC participate in the Medicare managed care market. Regence offers a Medicare Advantage plan and GHC offers a Medicare Advantage and Medicare Advantage Prescription Drug plan. PacifiCare also participates in the Medicare market as well.

Recent changes in Medicare create new business opportunities and risks for carriers participating in this market. The enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) has ensured that Medicare Advantage plans will play a significant role in the future in covering people on Medicare and in providing the new drug benefit. Specifically, MMA created a comprehensive voluntary prescription drug plan for Medicare beneficiaries, known as Medicare Part D. Medicare Part D is delivered through private risk-bearing entities under contract with the Centers for Medicare & Medicaid Services (CMS). As with all Medicare business, Medicare is not regulated at the state level.

Part D coverage for beneficiaries enrolled in a prescription drug plan began on January 1, 2006. The drug benefit is offered to beneficiaries through both Part D Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs). PDPs are stand-alone drug only plans for beneficiaries enrolled in Medicare. MA-PD plans are offered to MA beneficiaries in conjunction with MA plans; these MA-PD plans may serve to increase enrollment in Medicare managed care.

While risk corridors help mitigate the risk, the Part D Program is completely new and most pricing could not be developed using historical information. Furthermore, both MA and PDP products will have premiums dependent on the reported risk status of the enrollees, which is dependent on the quality of coding of the providers. Thus, it will take several years for the impact of this offering to be well understood, as evidenced by the vastly differing estimates of the cost of Part D presented to Congress during the development of the MMA legislation. In addition to claims uncertainty, the timing and amounts of payments are also uncertain in government products such as Medicare, which adds to the risk of offering these products.

In sum, the nature of the risk in the Medicare market is still not yet well understood. Product restructuring under MMA, combined with expansion into new products and higher premium levels for Medicare products, increases carrier risks and surplus demand relative to premium dollars. Key areas of risk to consider in the Medicare market include:

- Effective Part D marketing may result in significant shifts in enrollment patterns across carriers in the Medicare market;
- The Medicare Part D Program is new and most pricing could not be developed using historical information;

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[27] Kaiser Family Foundation, State Coverage Initiatives, Coverage Profile: Washington, Overview of Medicaid and SCHIP Coverage (2005), *available at* http://statecoverage.net/profiles/washington.htm.

- June 2006 Deadline for Medicare 2007 bidding process prevented use of 2006 experience;
- The nature and outcome of competitive bidding increases uncertainty about the adequacy of supplemental premiums;
- Both MA and PDP products will have premiums dependent on the reported risk status of the enrollees, which is dependent on the quality of coding of the providers and carrier claims data;
- Budget neutrality requirements add uncertainty to the rate setting process;
- Although the premiums received are adjusted for health status, there is still uncertainty about who will enroll and how successful the new offering will be given that the product is new;
- Subsequent years of premium increases may depend not only on the actual underlying cost trends, but the availability of funding; and
- Introducing or expanding Medicare products means a sudden large need for surplus to back the product given the new enrollment.

All of these issues must be considered when establishing appropriate surplus levels to guard against potential risks of entering this new market.

B. Business and Market Overview

The following section discusses the tools and background information necessary for analyzing health carrier surplus. In order to fully understand and compare health carrier surplus across carriers, we recommend using two types of measures: Risk-based capital (RBC) and surplus as a percent of revenue (SAPOR) as opposed to raw surplus numbers.

RBC was introduced as a tool by which regulators could asses the adequacy of surplus after reviewing the nature of the risks that different companies face, as well as varying degrees of volatility that arise with alternative sets of risks.

SAPOR is another measure that used in analyzing health carrier surplus given that it allows for carrier comparison among carriers with both high and low revenues.

We also provide measures for analyzing a carrier's efficiency, medical management, and economies of scale. Finally, we conclude this section with financial strength ratings given the connection between surplus and credit ratings. A carrier that holds less surplus is likely to get a lower credit rating from the independent rating agencies, forcing the carrier to pay higher interest costs whenever it needs to borrow money.

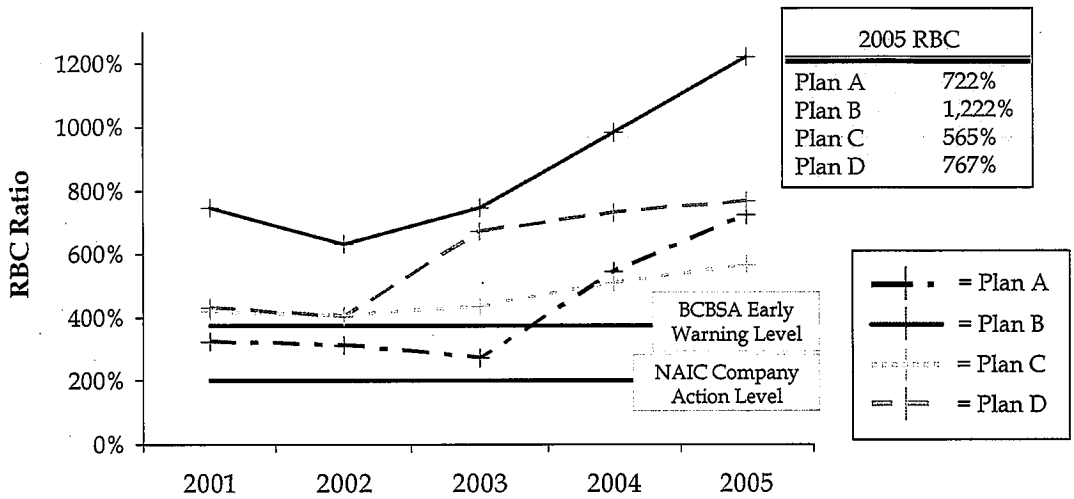
RBC

The National Association of Insurance Commissioners (NAIC) defines the RBC ratio as a measurement of the amount of capital (assets minus liabilities) a carrier has as a basis of support for the degree of risk associated with its company operations and investments. This ratio identifies companies that are inadequately capitalized by comparing the company's capital to the minimum amount of capital that the regulatory authorities believe is necessary to support

insurance operations. In financial terms, the RBC statistic is a ratio of the authorized control level risk-based capital of carrier to its total adjusted capital.[28]

The chart below depicts historical RBC values for the four carriers reviewed in this report, Regence, Premera, GHC, and PacifiCare in the Washington State insurance market. The chart is blinded given Washington statutory RBC confidentiality requirements. Of the four carriers, all showed an increase in RBC between 2001 and 2005. With the exception of one carrier, RBC ratios were similar in 2005. Further, Plans A and B grew their RBC rapidly between 2003 and 2005.

Historical RBC Values for Selected Washington State Carriers - 2001-2005



Notes: Lewin Analysis. RBC for Plan B as of June 30, 2006 dropped to 1154%, and RBC for Plan C as of June 30, 2006 increased to 629%.
2002 - 2005 NAIC filings *available at* https://external-apps.naic.org/insData/index.jsp.

Plans listed in the key to this chart are not in the same order as plans listed in keys to subsequent charts.

SAPOR

Surplus as a percent of revenue (SAPOR) measures capital and surplus as a percentage of insured premium revenue net of reinsurance. A high SAPOR percentage would indicate that a carrier incurred large profits or a decrease in revenue.

$$\text{SAPOR} = \frac{\text{Total surplus}}{\text{Total revenue}}$$

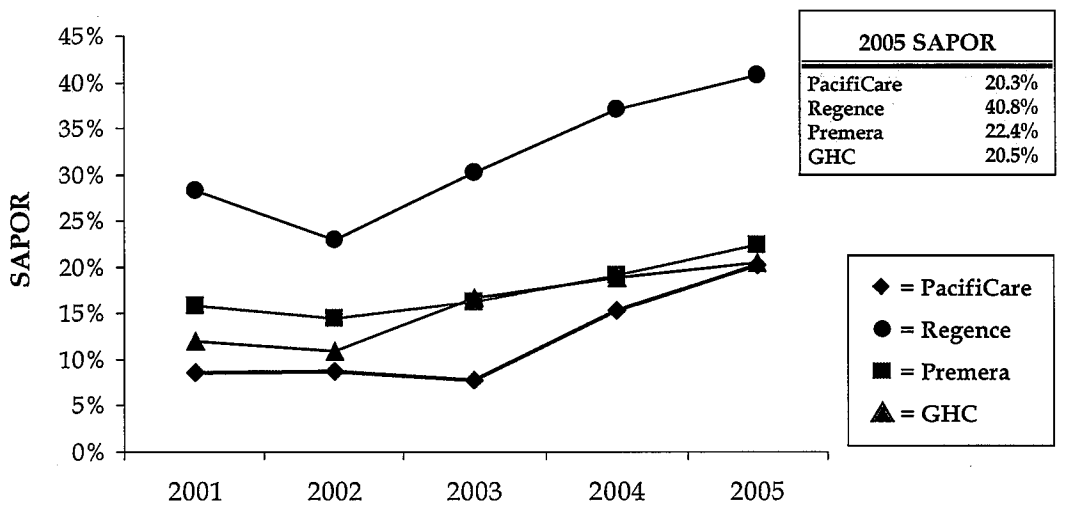
SAPOR is a measure of surplus that allows for the comparison of carriers with varying levels of revenue. For example, if a carrier were to have a SAPOR of 50% in 2005, then the carrier is holding a level of surplus roughly equivalent to half of its annual revenue for the prior year.

[28] NAIC, *available at* http://www.naic.org/consumer_glossary.htm#R.

This means that if the carrier were to stop taking in revenue, it would be able to fund those costs incurred with existing surplus for about six months (50% of the year).

The chart below depicts historical SAPOR values for Regence, Premera, GHC and PacifiCare between 2001 and 2005. After a slight decline in SAPOR between 2001 and 2002, all four carriers experienced increases in SAPOR between 2002 and 2005. This increase indicates that profits are increasing more than revenue and costs, since these carriers' revenues continued to increase between 2001 and 2005 (with the exception of PacifiCare, which experienced decreases in revenue between 2003 and 2005). Regence has held the highest SAPOR consistently over the five-year period reviewed.

Historical SAPOR Values for Selected Washington State Carriers - 2001-2005



Notes: Lewin Analysis.
2002 – 2005 NAIC filings *available at* https://external-apps.naic.org/insData/index.jsp.

Capital & Surplus (Net Worth)

The chart below depicts actual surplus numbers for Regence, Premera, GHC, and PacifiCare between 2001 and 2005. It is not recommended to compare carriers using raw surplus numbers as shown in the chart because it does not take into account the differences in each carrier's licensure and operation, including the nature of the risks that different carriers face, as well as varying degrees of volatility that arise with alternative sets of risks.

Capital & Surplus (Net Worth) - Rounded to nearest thousand	2001	2002	2003	2004	2005
Regence Blue Shield	$411,644	$345,639	$500,955	$618,116	$716,582
Premera Blue Cross	$328,989	$311,613	$373,072	$445,991	$525,447
Group Health Cooperative	$172,086	$176,204	$300,815	$377,985	$438,570
PacifiCare	$42,961	$47,493	$45,423	$86,538	$99,971
WA State Domestic Health Report, (2005)					

MLR

The Medical Loss Ratio (MLR) is the percentage of premium dollars spent on the provision of health services. MLR is the ratio between medical costs and the amount of money members paid to the carrier in premiums. Medical costs are generally comprised of inpatient hospital costs, outpatient hospital costs, physician services, and prescription drug spending[29] and other direct medical care expenses. MLR is calculated using the following formula:

$$\text{MLR} = \frac{\text{Total medical costs}}{\text{Total premium and health care revenues earned}}$$

Low MLR can be achieved either by incurring a low level of medical expenditures or by accruing a high level of insurance premiums. As a result, some view a low ratio as an indicator of health carrier efficiency, solvency, and creditworthiness, while others view a low ratio as proof of lesser quality, risk skimming, and high profits.

High MLR can be achieved either by incurring a high level of medical expenditures or by accruing a low level of insurance premiums. Therefore, to some, a high medical loss ratio indicates that a health carrier spends a high percentage of its premium revenue on medical care for carrier enrollees, while to others high MLR indicates poor care management and a trend toward insolvency.[30]

To provide some context to the concept of MLR, we note that in the Washington individual market, if a carrier's MLR is less than 72% then the carrier is required to remit the difference between the actual MLR and a MLR at 72% to the Washington State Health Insurance Pool

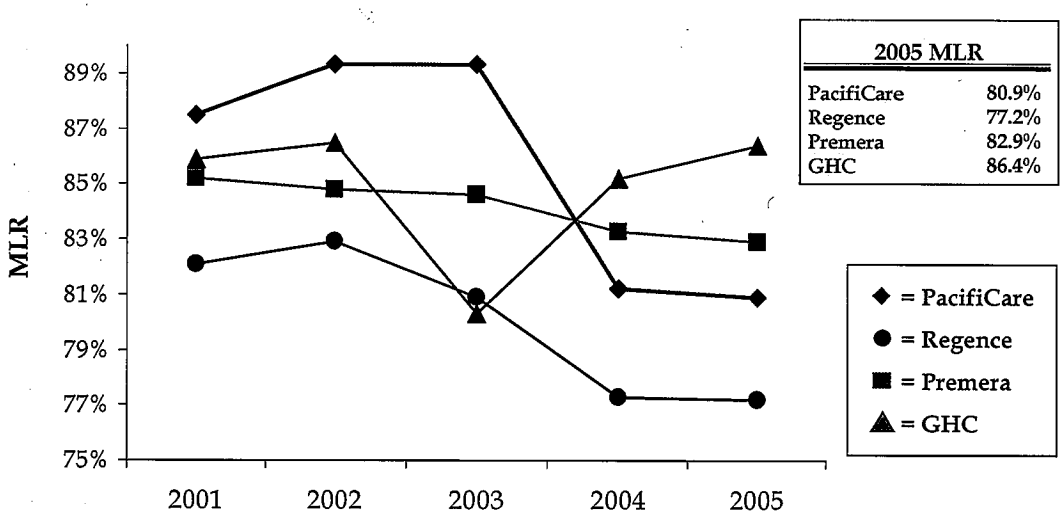
[29] "Managed Care," Centers for Medicare and Medicaid Services. (March 24, 2003).

[30] J. Robinson, "Use and abuse of the medical loss ratio to measure health plan performance," Health Affairs, 16:4, 176-187 (1997).

(WSHIP).[31] This serves as a disincentive to prevent carriers from making excessive profits or spending inadequate sums on patient care.

The chart below depicts historical MLR values for Regence, Premera, GHC and PacifiCare between 2001 and 2005 in the Washington health insurance market. All four carriers have demonstrated a decreasing trend in MLR between 2003 and 2005 except GHC, which demonstrated an increase. As of year end 2005, Regence, the largest carrier of the group, had the lowest MLR.[32]

Historical MLR Values for Selected Washington State Carriers - 2001-2005



Notes: Lewin Analysis.
WA State Domestic Health Report, (2005).

Administrative Cost Trends

Overall administrative costs can be measured in various ways. Two ways include:

(1) Administrative loss ratio (ALR);

(2) Administrative costs on a per member per month (PMPM) basis.

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[31] David Peel, "Have We Mastered the Underwriting Cycle?" Washington Healthcare News, (November 2006); *See* RCW § 48.20.025(6) (disability carriers), § 48.44.017(6) (HCSCs), and § 48.46.062 (6) (HMOs).

[32] A combination of events resulted in reduction of MLR for Regence. Actual claims in 2002 had come in higher than projected, primarily due to higher than anticipated utilization. In 2003, MLR also came in higher than planned, and 2005 came in lower. A re-evaluation of desired contributions by line of business resulted in more appropriate rates being delivered. Other factors included slight changes in business mix, the introduction of several disease management programs (Special Beginnings, Healthy Heart, Asthma and Diabetes), improved bundling edits and post-pay auditing (CCE/CCI code pairing software, CGI audit software), and improvements in trend forecasting. Regence BlueShield Response to Lewin Follow-Up Questions – 11/9/06, E-mail, (November 9, 2006).

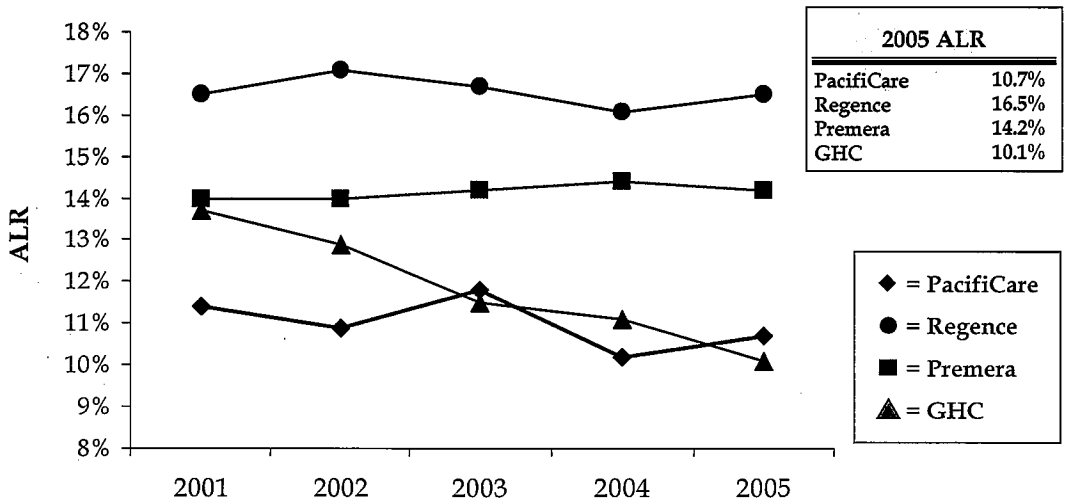
ALR

The Administrative Loss Ratio (ALR) is the percentage of premium dollars spent on administrative expenses.[33] ALR is calculated using the following formula:

$$\text{ALR} = \frac{\text{Administrative Expenses}}{\text{Total revenue}}$$

The following factors affect the degree of administrative expenses a carrier incurs: the type of managed care arrangement, accounting methods, size of membership, administrative requirements, and allocation of revenue and expenses among payors.[34] However, carriers differ widely in the extent to which they follow these guidelines. As an example, some consider utilization review costs as medical costs, whereas others treat them as administrative costs. As seen in the chart below, Regence, Premera, GHC and PacifiCare all have demonstrated a consistent ALR except GHC, which demonstrated a decline. Of the carriers reviewed, Regence and Premera had the highest overall ALR.

Historical ALR Values for Selected Washington State Carriers - 2001-2005



Notes: Lewin Analysis.
WA State Domestic Health Report, (2005).

Admin PMPM

Admin PMPM measures the costs "incurred on behalf of each member each month,"[35] and is measured in actual dollars. Admin PMPM differs from the administrative loss ratio (ALR) in

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[33] "A Guide to Monitoring Managed Care," Families USA, *available at* http://families usa.org/resources/tools-for-advocates/guides/monitoring-medicaid-mc-7.html.

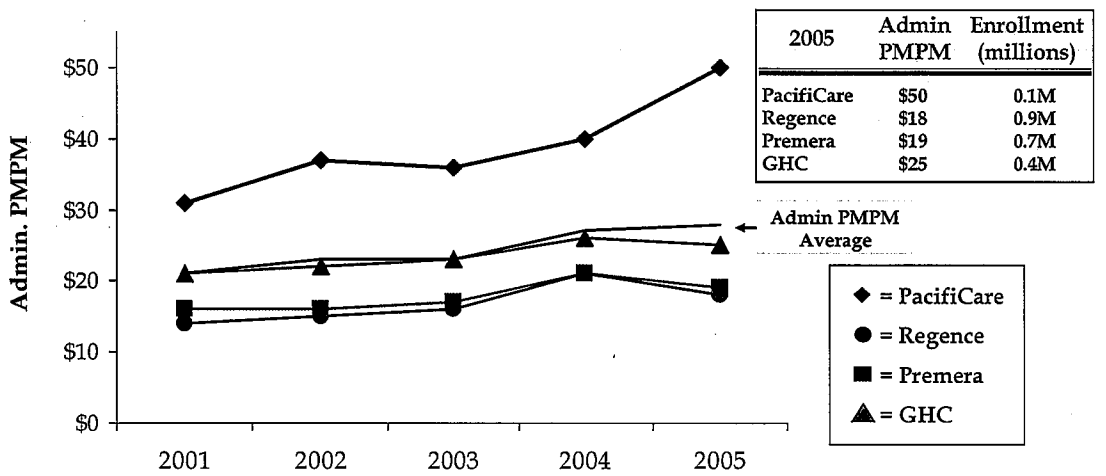
[34] *Ibid.*

[35] K. Sacia and R. Dobson, "Health Plan Administrative Cost Trends," Blue Cross Blue Shield Association, (February 20, 2003) *available at* http://bcbshealthissues.com/relatives/20445.pdf.

that ALR measures "administrative costs relative to total premium"[36] charged and is measured in percent of total premium charged. Admin PMPM is often associated with economies of scale: high Admin PMPM may indicate lower economies of scale and low Admin PMPM may indicate greater economies of scale.

The chart below depicts Admin PMPM values for Regence, Premera, GHC and PacifiCare in the Washington State insurance market. PacifiCare has significantly higher Admin PMPM than the other three carriers. Regence and Premera fall below the average of these carriers, and GHC follows the average closely. Not surprisingly, the larger carriers in Washington appear to demonstrate higher economies of scale.

Historical Admin PMPM Values
for Selected Washington State Carriers - 2001-2005



2005	Admin PMPM	Enrollment (millions)
PacifiCare	$50	0.1M
Regence	$18	0.9M
Premera	$19	0.7M
GHC	$25	0.4M

Notes: Lewin Analysis.
2002 - 2005 NAIC filings *available at* https://external-apps.naic.org/insData/index.jsp.

A.M. Best Company Financial Strength Ratings

A.M. Best Co. is a worldwide insurance-rating and information agency with long-established experience in the issuance of financial strength ratings for carriers. These ratings are based on a comprehensive quantitative and qualitative evaluation, or a company's balance sheet strength, operating performance, and business profile. The table below includes A.M. Best's ratings for six of the largest carriers in Washington State as of March 21, 2006. The ratings, which are relatively high across the board, indicate A.M. Best's confidence in these carriers' financial strength and in their abilities to meet their ongoing obligations to policyholders. A.M. Best rated both PacifiCare and Regence as "Excellent", Premera, Community Health and GHC as "Very Good" with Molina as "Fair." We note that there is an important connection between surplus and credit ratings. A carrier that has less surplus is likely to get a lower credit rating from the independent rating agencies, forcing the carrier to pay higher interest costs whenever it needs to borrow money.

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[36] *Ibid.*

A.M. Best Financial Strength Ratings – March 21, 2006

Health Plan	Best's Financial Strength Rating*
PacifiCare of Washington	A -
Regence BlueShield	A -
Premera Blue Cross	B ++
Community Health Plan of Washington	B +
Group Health Cooperative	B +
Molina Healthcare of Washington, Inc.	B -

A.M. Best Ratings Guide
Secure: A ++, A + (Superior); A, A - (Excellent); B ++, B + (Very Good)
Vulnerable: B, B - (Fair); C ++, C + (Marginal); C, C - (Weak); etc.

Note: Lewin has selected A.M. Best's financial strength ratings[37] given that it rates all the health carriers reviewed in this study. Other relevant measures include those published by Standard & Poor's, which are also available online.[38]

[37] A.M. Best ratings *available at* http://www3.ambest.com/ratings/RatingsSearch.asp?bl=0&sr=4.

[38] S&P ratings *available at* https://www2.standardandpoors.com/servlet/Satellite?pagename=sp/Page/CreditRatingsDeskPg&r=1&l=EN&b=2&s=142&ig=313.

C. Plan Profiles

In addition to the specific indicators of financial health noted above, regulators should consider carrier-specific characteristics in evaluating surplus levels. The following section provides specific carrier profiles for Regence, Premera, GHC and PacifiCare. We also provide in this section enrollment numbers for these carriers and their affiliates, and a discussion of trends in their pricing and surplus. These items are important considerations in evaluating carrier-specific characteristics and risks.

The table below displays enrollment estimates by market at year end 2005 for Regence, Premera, PacifiCare and GHC including these carriers' affiliate entities. With the exceptions of Premera's Lifewise in the individual market and Group Health Options Inc. (GHO) in the small group market, Regence, Premera, PacifiCare and GHC have higher enrollments in each of the markets analyzed (individual market, small group market, and large group market) than their affiliated entities.

Total Enrollment Estimates
for Selected Washington State Carriers and Subsidiaries - 2005

2005 Enrollment Estimates*	Individual	Small Group	Large Group	Basic Health Plan
Regence BlueShield	87,954	138,043	236,159	0
Asuris Northwest Health	1,259	12,088	11,099	0
Premera Blue Cross	11,054	121,749	408,731	0
Lifewise Health Plan of WA	77,501	0	260	0
Group Health Cooperative	20,832	6,942	159,914	13,741
Group Health Options, Inc.	0	13,379	87,195	0
KPS Health Plans	4,251	6,117	18,887	0
PacifiCare	82	1,445	26,564	0

*Calculated dividing calendar year member months by 12.
Annual Statements, WA OIC website. <https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp>

Trends in Pricing and Surplus: 2002-2005

The charts in Appendix A illustrate the rates of increase of surplus and pricing for Regence, Premera, GHC and PacifiCare between 2002 and 2005. Based on Lewin analysis, it appears that generally, the rates of increase for both surplus and pricing increased significantly between 2002 and 2005. The only negative rates of change were those of GHC's pricing in 2003-2004, PacifiCare's surplus in 2002-2003, and PacifiCare's pricing over the entire period from 2002 to 2005. Also, it was common that all four carriers' rates of increase of surplus were always greater than their rates of increase of pricing during this period. Even when PacifiCare's surplus decreased in 2002-2003, PacifiCare's pricing decreased by a greater amount.

Regence

Regence is a non-profit health care service contractor, established through the merger of Pierce County Medical Bureau, Inc. and King County Medical Blue Shield, founded originally in 1917 and 1933, respectively.[39] Regence BlueShield is a subsidiary of The Regence Group, a large non-profit carrier holding company that encompasses many other organizations, including Regence Rx, Inc., Regence Blue Cross Blue Shield of Oregon, Asuris Northwest Health, and Regence Life and Health Insurance Company.[40] A complete organization chart of The Regence Group is available in Appendix B. Regence is an independent licensee of the Blue Cross and Blue Shield Association but unlike many other Blues, is not a "charitable and benevolent" organization nor is it deemed the "insurer of last resort" in the Washington market.[41] Further, Regence is required to pay both federal and state taxes.[42]

As of year end 2005, Regence was Washington State's largest health carrier by enrollment, with approximately 868,000 members.[43] Currently, Regence participates in the Individual, Small Group, Large Group, PEBB, Medicare, and Federal Employee markets. Regence withdrew its offer of the Basic Health Plan product in January 2005.[44]

Premera

Premera is a non-profit health care service contractor, established through the merger of Medical Service Corporation and Blue Cross of Washington and Alaska, which trace their origins to 1933 and 1945, respectively.[45] Premera's subsidiaries include Premera First, Inc., LifeWise Health Plan of Washington, and Premera Blue Cross Blue Shield of Alaska Corp.[46] A complete organization chart of Premera is available in Appendix B. Premera is an independent licensee of the Blue Cross and Blue Shield Association but unlike many other Blues, is not a "charitable and benevolent" organization nor is it deemed the "insurer of last resort" in the Washington market.[47] Further, Premera is required to pay both federal and state taxes. [48]

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39 "Company Info," Regence BlueShield, *available at* http://www.wa.regence.com/about/company/regenceGroup/.

40 Regence BlueShield 2005 Annual Statement filed on the OIC website *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp.

41 Ellison, Nancy, Director of Government Affairs, et al., Regence Blue Shield. Phone interview. (October 11, 2006) *citing* Articles of Incorporation.

42 Contrary to popular understanding, Regence (as a Blue Cross Blue Shield carrier) is subject to federal taxes. An amendment to the Internal Revenue Code in 1986 revoked the Blue's federal tax-exempt status, as Congress reasoned that the activities engaged in by Blue plans are fundamentally commercial rather than charitable and that tax exemption gave the plans an unfair competitive advantage over commercial competitors.

43 Washington Domestic Health Report, (2005).

44 Ellison, Nancy, Director of Government Affairs, et al., Regence Blue Shield. Phone interview. (October 11, 2006)

45 "History: The Premera Blue Cross Story," Premera Blue Cross, *available at* https://www.premera.com/stellent/groups/public/documents/xcpproject/CompanyHistory.asp.

46 Premera Blue Cross 2005 Annual Statement filed on the OIC website, *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp.

47 Pierce, John, Special Counsel, Legal and Regulatory Affairs Department, et al., Premera Blue Cross. Phone interview. (October 13, 2006) *citing* Articles of Incorporation of Premera Blue Cross.

48 Contrary to popular understanding, Premera (as a Blue Cross Blue Shield carrier) is subject to federal taxes. An amendment to the Internal Revenue Code in 1986 revoked the Blue's federal tax-exempt status, as Congress reasoned that the activities engaged in by Blue plans are fundamentally commercial rather than charitable and that tax exemption gave the plans an unfair competitive advantage over commercial competitors.

As of year end 2005, Premera was Washington State's second largest health carrier by enrollment with nearly 657,000 members.[49] Premera participates in the Individual, Small Group, Large Group, PEBB, Medicare Supplement, and Federal Employee markets. Premera withdrew its offer of the Basic Health Plan product in June 2004.[50]

Group Health Cooperative

GHC founded in 1947, is a consumer-governed, non-profit HMO that coordinates care and coverage.[51] GHC's subsidiaries/affiliates include Group Health Options, Inc., KPS Health Plans, Group Health Northwest (currently not active), and The Community Health Foundation.[52] A complete organization chart of GHC is available in Appendix B. GHC is organized for the purposes of being a "charitable, benevolent, scientific, medical, and educational" organization.[53] GHC is exempt from federal taxes given its non-profit status, but pays state taxes.

As of year end 2005, GHC was Washington State's third largest health carrier by enrollment with nearly 418,000 members.[54] GHC participates in the Individual, Small Group, Large Group, Healthy Options (Medicaid), Basic Health Plan, Medicare, PEBB, and Employee markets.[55]

PacifiCare

Established in 1986, PacifiCare is a for-profit, health care service contractor.[56] PacifiCare of Washington, Inc is a wholly owned subsidiary of PacifiCare Health Plan Administrators, Inc., which is a wholly owned subsidiary of PacifiCare Health Systems LLC, which is a wholly owned subsidiary of UnitedHealth Group Incorporated. As of year end 2005, PacifiCare was among Washington State's medium sized health carriers by enrollment with approximately 69,000 members.[57] PacifiCare participates in the Small Group, Large Group, PEBB, Medicare, and Federal Employee markets.[58]

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49 Washington Domestic Health Report, (2005).

50 Pierce, John, Special Counsel, Legal and Regulatory Affairs Department, et al., Premera Blue Cross. Phone interview. (October 13, 2006).

51 "About Group Health, Group Health Cooperative," Group Health Cooperative *available at* http://www.ghc.org/about_gh/index.jhtml.

52 Group Health Cooperative 2005 Annual Statement filed on the OIC website, *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp.

53 Agreement of Association of Group Health Co-operative of Puget Sound, Approved and Filed, (December 22, 1945).

54 Washington Domestic Health Report, (2005).

55 "Health Plans," Group Health Cooperative, *available at* http://www.ghc.org/health_plans/index.jhtml.

56 "PacifiCare: Washington," PacifiCare, *available at* http://www.pacificare.com/commonPortal/application?origin=mp_leftnav.jsp&event=bea.portal.framework.internal.portlet.event&pageid=CorporateSiteContentDisplay&portletid=CorporateSite&wfevent=link.viewarticle&navnode=CompanyProfiles.3.9.

57 Washington Domestic Health Report, (2005).

58 "Health Plans and Products," PacifiCare *available at* http://www.pacificare.com/commonPortal/application?origin=hnav_bar.jsp&event=bea.portal.framework.internal.portlet.event&pageid=mp_pagehometeaser&portletid=mp_contentdisplay&wfevent=link.viewarticle&navnode=HealthPlans.1.

D. Market Profiles

In addition to carrier-specific characteristics, regulators should understand the pricing and profitability within key Washington markets. The following section provides market profiles for the individual commercial market, small group commercial market and large group commercial market. In each of these markets, we provide profit margin and pricing analyses for Regence, Premera, GHC and PacifiCare. We also provide these analyses for Lifewise, a Premera subsidiary for the individual market and GHO, a GHC subsidiary for the small group market given these carriers' high enrollment in their respective markets.

Overall, as discussed below, pricing tends to increase at a regular rate in all markets over time. Changes in profit margin have greater variability during the same period. It appears that in 2002, among the carriers reviewed, carriers achieved the highest profit margins on average in the small group market. By 2005, higher profit margins on average were being achieved in the individual market. It is important to note that Premera exited the individual market in 2004; since that time Premera holds only a small amount of individual market membership while its subsidiary, Lifewise, has emerged as a major carrier in the individual market with low profit margins in that market. Further, profit margins were relatively low in the large group market from 2002 to 2005. In 2004 and 2005, it appears Regence achieved profit margins that were either the highest or nearly the highest among their peers in all markets reviewed.

Individual Market

In 1993, regulators placed health carriers under strict regulations due to the passing of the Washington Health Services Act. Throughout the mid-to late 1990s, enrollments increased considerably in the individual market and then the market collapsed.[59] In 1999 and 2000, Regence, Premera, and GHC stopped selling individual products in the State of Washington. The carriers cited adverse selection for their decisions.[60] To solve this problem, in 2000, Washington's Governor struck a deal with the health carriers in which the Office of the Insurance Commissioner would no longer set the rates in the individual market, and health carriers could underwrite based on risk.[61] Further, State lawmakers passed legislation that allowed carriers to rate individual products up to 72% Medical Loss Ratio or MLR (MLR is medical claims expense divided by premium income). If a carrier's MLR is less than 72% then the carrier is required to remit the difference between the actual MLR and a MLR at 72% to the Washington State Health Insurance Pool (WSHIP).[62]

WSHIP, the state's high risk pool, receives its financing through premiums and assessments to carriers.[63] New applicants are also required to fill out a health risk assessment questionnaire

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[59] Paul Schlienz, "Individual Insurance Market Resurrected," Washington Business Magazine, (March 2006), *available at* http://www.awb.org/cgi-bin/absolutenm/templates/?a=1241&z=3

[60] David Peel, "Have We Mastered the Underwriting Cycle?" Washington Healthcare News, (November 2006).

[61] Paul Schlienz, "Individual Insurance Market Resurrected," Washington Business Magazine, (March 2006), *available at* http://www.awb.org/cgi-bin/absolutenm/templates/?a=1241&z=3

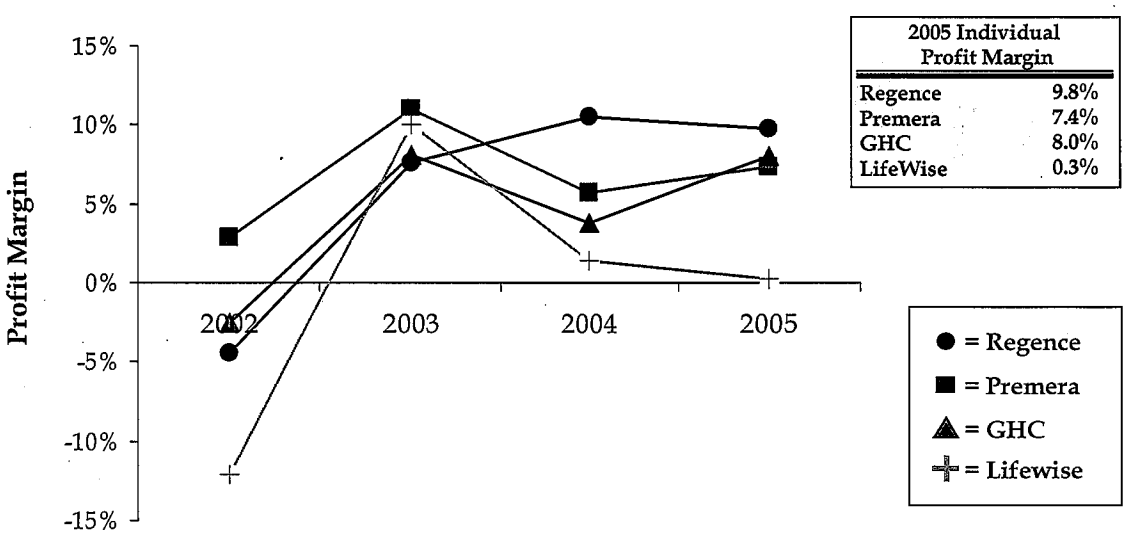
[62] David Peel, "Have We Mastered the Underwriting Cycle?" Washington Healthcare News, (November 2006); *See* RCW § 48.20.025(6) (disability carriers), § 48.44.017(6) (HCSCs), and § 48.46.062 (6) (HMOs).

[63] Kaiser Family Foundation, State Coverage Initiatives, Coverage Profile: Washington, Overview of Medicaid and SCHIP Coverage (2005), *available at* http://statecoverage.net/profiles/washington.htm. *See* RCW Ch. 48.41; WAC § 284-91; *see also* https://www.wship.org/Default.asp.

that disqualifies the applicant for coverage if the responses result in a higher score than allowed. Approximately 8% of people are expected to fail the questionnaire and those that fail are eligible to join WSHIP. However, premiums charged by WSHIP are much higher than rates available from the three carriers under individual coverage and thus, the take-up rates are low.

The individual health insurance market represents approximately five percent of Washington State's insured consumers. This group consists largely of self-employed individuals and workers at companies that do not offer health benefits.[64] The chart below depicts historical profit margin values for Regence, Premera, and GHC (as well as Premera's Lifewise because of its significant enrollment) in the Washington State individual market. All carriers showed an increase in profitability between 2002 and 2003. Changes in profitability varied across carriers between 2003 and 2005. Over the same period, all carriers showed a positive profit margin in the individual market, despite some carriers showing decreasing profits.

Historical Profit Margin Values
for Selected Washington State Carriers – Individual Market - 2002-2005

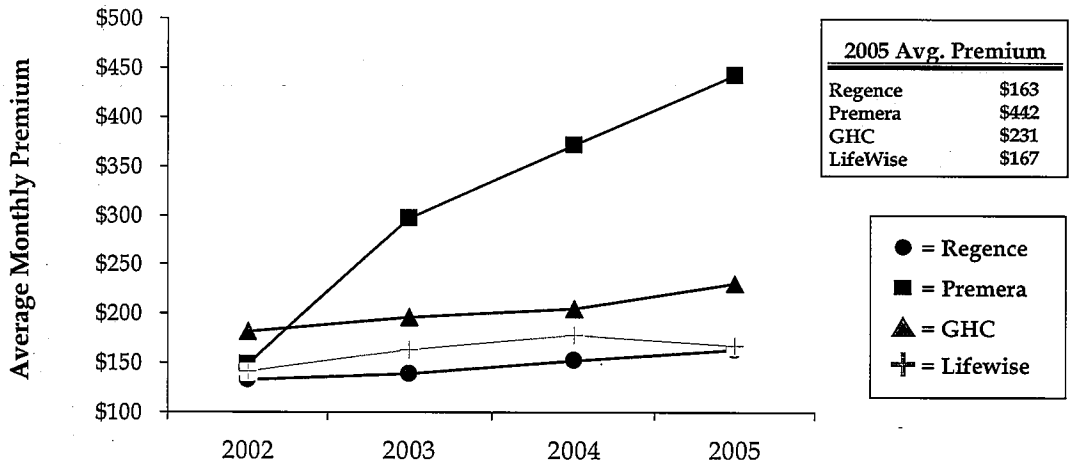


Notes: Lewin Analysis. In order to examine individual market pricing, Lewin analysis considered overall individual market financials and did not account for variation within a plan's individual product offerings. Please note: given PacifiCare's minimal enrollment in this market, the company has been excluded here.
2002 – 2005 Annual Statements, WA OIC website *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp

[64] Washington State OIC website: http://www.insurance.wa.gov/factsheets/factsheet_detailprint.asp?FctShtRcdNum59. Between 2002 and 2005, enrollment amongst these carriers increased, with the exception of Premera, which exited the individual market in 2004, holding only a small amount of individual market membership post-2004. Health Plan 2002-2005 Annual Statements filed on the OIC website, *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp.

Between 2002 and 2005 there was a general trend of increasing prices in the individual market among the carriers reviewed. All carriers showed an increase in pricing over time with the exception of Lifewise in 2005. Between 2002 and 2005, Premera showed the most considerable price increase among these carriers. There appears to have been a positive correlation between pricing and profitability between 2002 and 2003, though not between 2003 and 2005. Of the carriers below, Regence had the lowest average pricing in the individual market. Further, it is important to note that Regence implemented rate decreases in its individual lines effective July 1, 2006.

Historical Pricing Values
for Selected Washington State Carriers – Individual Market - 2002-2005



Notes: Lewin Analysis. In order to examine individual market pricing, Lewin analysis considered overall individual market financials and did not account for variation within a plan's individual product offerings. Please note: given PacifiCare's minimal enrollment in this market, the company has been excluded here.
2002 – 2005 Annual Statements, WA OIC website *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp.

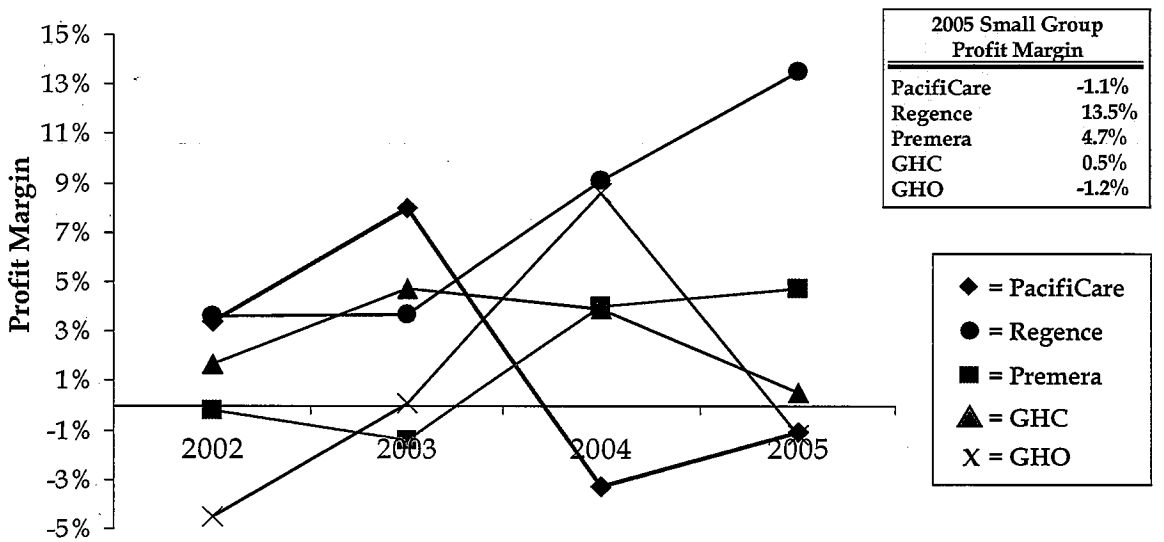
Small Group Market

The Washington small group market size is defined as employers or groups of 2-50[65] individuals or employees. Small group plans compose a large proportion of the overall Washington State insurance market.

[65] Kaiser Family Foundation, State Coverage Initiatives, Coverage Profile: Washington, Overview of Medicaid and SCHIP Coverage (2005), *available at* http://statecoverage.net/profiles/washington.htm "Small employer" or "small group" is defined at RCW 48.43.005(24).

The chart below depicts historical profit margin values for Regence, Premera, GHC and PacifiCare (as well as Group Health Options (GHO) because of its significant enrollment) in the Washington State small group market. Between 2003 and 2005, Premera and Regence profits increased considerably, while GHC, PacifiCare, and GHO experienced diminished profitability. These changes occurred against the backdrop of overall declining enrollment among all carriers reviewed from 2002 to 2005 with the exception of GHO. Over the time period studied, the majority of carriers experienced positive profit margins in the small group market.

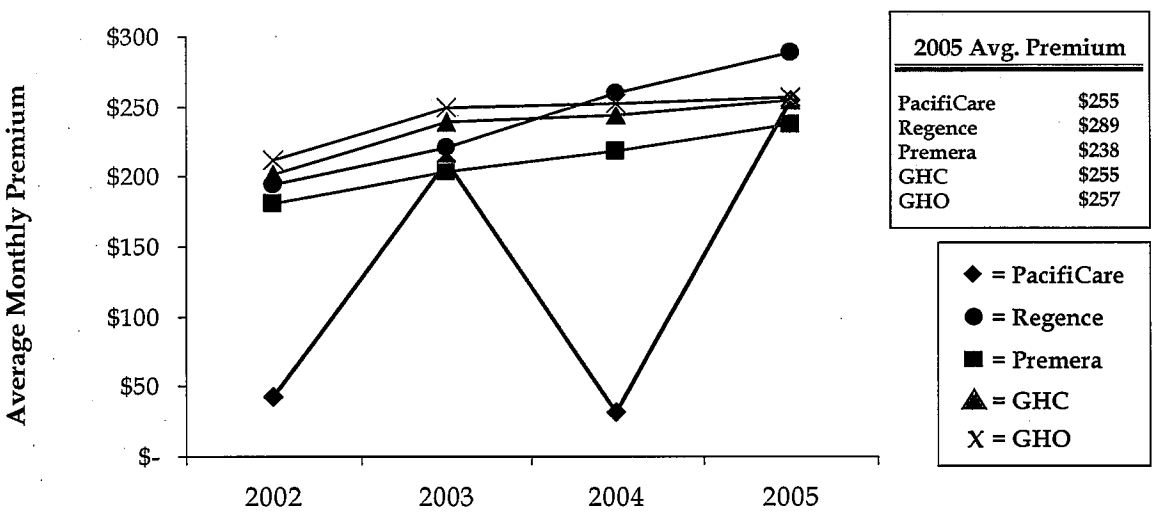
Historical Profit Margin Values
for Selected Washington State Carriers – Small Group Market - 2002-2005



Notes: Lewin Analysis. In order to examine small group market pricing, Lewin analysis considered overall individual market financials and did not account for variation within a plan's individual product offerings.
2002 – 2005 Annual Statements, WA OIC website: *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp.

All payors demonstrated consistent price increases between 2002 and 2005 with the exception of PacifiCare. PacifiCare's average small group pricing fluctuated considerably. There appears to have been some positive correlation between pricing and profitability in the small group market between 2002 and 2005. Of the carriers below, Regence had the highest average pricing in the small group market as of 2005. However, it is important to note that Regence implemented rate decreases in its small group lines effective July 1, 2006.

Historical Pricing Values
for Selected Washington State Carriers – Small Group Market - 2002-2005

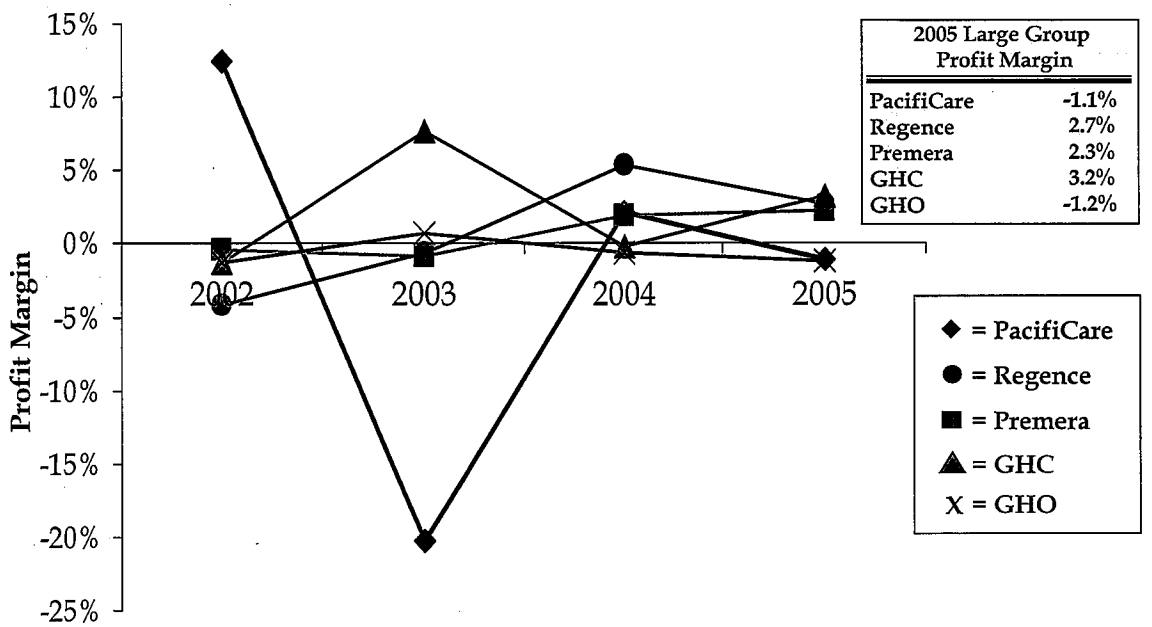


Notes: Lewin Analysis. In order to examine small group market pricing, Lewin analysis considered overall individual market financials and did not account for variation within a plan's individual product offerings.
2002 – 2005 Annual Statements, WA OIC website *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp.

Large Group Market

Employer benefit plans and other plans organized for 51 or more enrollees can be classified as "large group." The chart below depicts historical profit margin values for Regence, Premera, GHC and PacifiCare (as well as GHO because of its significant enrollment) in the Washington State large group market. From 2002 to 2005, Regence, Premera and GHC moved from negative profit margins to positive profitability, while GHO's profit margin declined. These changes have occurred against a backdrop of overall declining enrollment in the large group market among all carriers from 2002 to 2005 with the exception of GHO.

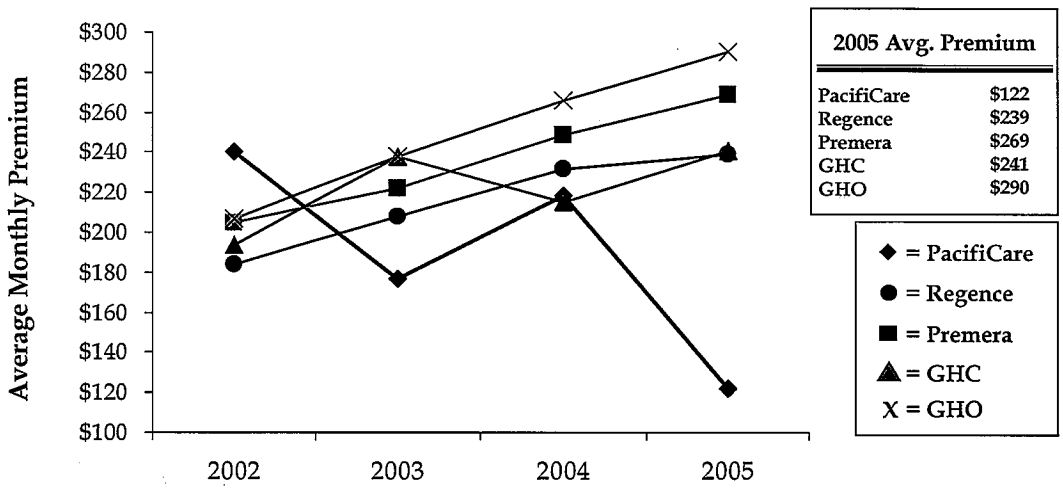
Historical Profit Margin Values
for Selected Washington State Carriers – Large Group Market - 2002-2005



Notes: Lewin Analysis. In order to examine large group market pricing, Lewin analysis considered overall individual market financials and did not account for variation within a plan's individual product offerings.
2002 – 2005 Annual Statements, WA OIC website *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp.

GHC and PacifiCare pricing changes have fluctuated considerably in the large group market. There appears to have been some positive correlation between pricing and profitability in the large group market between 2002 and 2005. It seems this correlation holds best for GHC and PacifiCare.

Historical Pricing Values
for Selected Washington State Carriers – Large Group Market - 2002-2005



Notes: Lewin Analysis. In order to examine large group market pricing, Lewin analysis considered overall individual market financials and did not account for variation within a plan's individual product offerings.
2002 – 2005 Annual Statements, WA OIC website *available at* https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp.

V. POLICY OPTIONS

In the last few years, the public's focus on the financial activities of health carriers has intensified. First, carriers in Washington, like health carriers nationwide, started experiencing large increases in their earnings. Second, the economy softened at the same time that health care costs swelled. This increased the state's numbers of uninsured and made it harder for those having insurance to afford it. Some stakeholders argued that Washington carriers should give up portions of their surpluses to help make health coverage more affordable. In consideration of these issues, the following section reviews several alternative policy options with regard to surplus regulation and provides a general framework for better understanding these types of regulations and their unintended consequences.

Capping Surplus

Regulators have multiple ways of influencing the affordability of insurance, of which the regulation of surplus through establishing surplus caps is one of the most indirect. Advocates often look to capping surplus as a strong policy option for state insurance departments in limiting surplus accumulation among carriers. A number of methods are available in defining a

surplus cap including RBC, a percentage of annual revenue or of annual claims and expenses. Hawaii, until June 2006, used as a trigger the level where a non-profit carrier's net worth exceeded 50% of its annual health care expenditures and operating expenditures as reported on the plan's most recent financial statement filed with the Commissioner[66] while Michigan uses a cap of an RBC ratio of 1000% for Blue Cross Blue Shield of Michigan[67] and Pennsylvania uses RBC target ranges for its four Blues plans (550% to 750% for its larger Blues plans: Highmark and Independence Blue Cross and 750% to 950% for its smaller Blues plans: Blue Cross of Northeastern Pennsylvania and Capital Blue Cross).[68]

The primary advantage of capping surplus levels is that it may slow the rate of premium growth if a carrier has surplus that is at or near its cap. However, it is important to note that a carrier may react by draining surplus in ways that do not involve rate relief. The carrier might increase spending on such things as infrastructure improvements (e.g., electronic medical records) to improve customer service and efficiency. Or, the carrier could make voluntary community benefit outlays, though doing so may run counter to the carrier's self-interest in building market share and improving performance and may encounter resistance from policy holders. However, the carrier could also increase salaries and bonuses for carrier executives.

In addition to uncertain benefits of doing so, there may also be adverse consequences of capping carriers' surpluses. First, the intervention could create market instability if premiums are set artificially low. Depending on the scale of the impact on premium rates, some competitors might be forced or choose to exit the market, leaving consumers fewer choices. Second, the short-term savings could be followed later by pricing spikes. Third, having less surplus is likely to cause an independent rating agency to lower a carrier's credit rating, forcing the carrier to pay higher interest costs whenever it needs to borrow money. Since limiting surplus levels can result in market disruption, reducing competition and pricing spikes, we look to other tools at the disposal of insurance regulators on surplus regulation.

Rate Regulation, and Increasing Regulatory Authority and Oversight

Traditionally, state insurance departments have attempted to influence premium levels in a number of ways, including setting standards for underwriting and rate-making, especially in the small-group and individual segments; rate filing and approval processes; and setting minimum medical loss ratios as is currently in effect in the Washington individual market (as described in Section IV of this report). These regulatory approaches focus on carriers' ability to generate earnings, rather than on how much surplus can or should be kept once earned.

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66 Haw. Rev. Stat. §§ 431:14F-101, 431:14F-106 (repealed), *available at* http://www.capitol.hawaii.gov/hrscurrent/Vol09_Ch0431-0435E/HRS0431/HRS_0431-0014F-0106.HTM; Lim, Lloyd, Administrator of Health Insurance Branch, Insurance Division, Hawaii Department of Commerce and Consumer Affairs. Phone interview. (November 2, 2006).

67 Mich. Comp. Laws §550.1204 (2003).

68 The Pennsylvania Legislative Budget and Finance Committee commissioned Lewin to conduct a study of the regulation and disposition of reserves and surpluses of the four Blue plans. Lewin found that the upper limits on surplus were reasonable. The Lewin Group, Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans, prepared for The Pennsylvania General Assembly Legislative Budget and Finance Committee (June 13, 2005), *available at* http://www.lewin.com/NR/rdonlyres/empv7jjik2vp4b6bq5bcsxlqmiq6fjezjrrbkdifcmnzinnvcsdrj3nlcpdukhuf7vzfzpignbibip/3193.pdf.

Because these approaches affect the rate-making process, they have a more direct and predictable impact on premium affordability than does capping surplus levels. In this way, states address health care affordability by providing their Insurance Commissioners with the regulatory authority and oversight to monitor and evaluate health carrier surplus accumulation in light of premium growth.

Currently, the Washington Insurance Commissioner may not use current RBC levels for rate-making, nor may the Commissioner consider RBC levels or introduce these levels as evidence in any rate proceeding or even to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a carrier or any affiliate is authorized to write. Rather, RBC is solely for use by the Commissioner in monitoring the solvency of carriers and the need for possible corrective action with respect to carriers.[69] However, the Commissioner may conduct examinations, investigations and hearings, in addition to those specifically indicated in the Washington Insurance Code, for the efficient administration of any provision of the Insurance Code.[70]

To increase the Commissioner's regulatory authority, the Commissioner's 2007 Office of the Insurance Commissioner Legislative Agenda contains a proposed bill that pertains to the regulation of health carrier surplus through rate regulation. Under this draft bill (Z-0152), the Commissioner will request the authority to restore individual market rate regulation to pre-2000 standards with two additions. These additions include file and use with sixty (60) days advance filing, and explicit authority to consider carrier surplus when reviewing rates.[71] We note, however, that any type of rate regulation must consider carrier solvency and the importance of regulating carriers on a level playing field. We recommend using additional market analysis and review, such as the market review in this report, in any type of rate regulation review and approval process as well. Further, any type of regulation that interferes *excessively* with traditional market forces and market pricing can have the unintended consequence of forcing carriers out of the market, which is analogous to what occurred in the Washington individual market prior to 2000.

Enhancing an Insurance Commissioner's regulatory authority is a policy option that can provide a stronger platform for regulatory oversight and scrutiny of health carrier surplus accumulation. The legislature in Rhode Island has chosen this route in addressing access and affordability issues. Instead of enacting a surplus cap as in the case of Michigan and Hawaii, or target surplus ranges as in the case in Pennsylvania, the Rhode Island legislature created a new position with direct oversight over health care and carriers and provided stronger regulatory authority for the newly created Health Insurance Commissioner position by passing the Rhode Island Health Care Reform Act. Prior to the passage of this Act, stakeholders proposed that Blue Cross Blue Shield of Rhode Island (BCBSRI) should give up some portion of its surplus to help make health coverage more affordable. Stakeholders wanted to ensure that BCBSRI, as a non-profit entity, was dedicated to providing affordable health care to the public. The impetus behind the Reform Act was based on legislative findings which indicated, among other things, that "... the power of health care insurers ... has become great enough to create a competitive

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[69] RCW § 48.43.335.

[70] RCW § 48.02.060(3).

[71] State of Washington, Office of the Insurance Commissioner, Legislative Agenda, (September 2006).

imbalance, reducing levels of competition and threatening the availability of high quality, cost-effective health care...."[72] Thus, the Rhode Island legislation directed the newly appointed Rhode Island Health Insurance Commissioner to focus on four key areas: guarding the financial solvency of health carriers, promoting consumer protection, encouraging the fair treatment of providers, and helping carriers improve access, quality and the efficiency of health service delivery. [73]

The legislature asked the Rhode Island Health Commissioner to provide recommendations for what appropriate insurance surplus levels might be for health insurers in Rhode Island. The broader purpose of the legislation is to improve the state of health care delivery in Rhode Island by making health insurance more affordable and available to the public. Since taking office, the Rhode Island Health Commissioner has conducted studies[74] on appropriate target surplus levels and now has objective ranges to use in any rate-making determinations. Further, the increased regulatory authority of the Rhode Island Health Commissioner provides him with a stronger platform to evaluate health carriers on issues of premium affordability, access, quality, and efficiency, which go beyond the traditional focus of most state insurance departments on health carrier solvency.

Transparency

Focusing on transparency in carrier financial reports, as well as cost and quality of health care services is a means of bringing long-term improvement to the healthcare system. The goal of increased transparency is to promote and reward competition between carriers based on quality and efficiency. The OIC currently publishes on its website carrier financial information. However, state law prevents the publishing of RBC levels of health carriers for public access.[75] Rather, RBC is solely for use by the Commissioner in monitoring the solvency of carriers and the need for possible corrective action with respect to carriers. Publishing RBC levels of carriers would allow for greater understanding of health carrier surplus levels within the framework of the NAIC minimum level and the BCBSA early warning level.

If the Commissioner gains the regulatory authority to conduct carrier rate review and approval in certain market segments, and uses carrier surplus as a factor in this process, such RBC publication could also provide greater disclosure to the public with regard to this process. Further, increased transparency of existing carrier financial information through in-depth market analysis and review, similar to the type of market review in this report, will also provide

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[72] R.I. Gen. Laws. § 42-14.5-1.1.

[73] R.I. Gen. Laws. § 42-14.5-1.2.

[74] The Office of the Health Insurance Commissioner (OHIC) commissioned The Lewin Group to assess the surplus levels of Rhode Island's three health plans, Blue Cross Blue Shield of Rhode Island, United HealthCare of New England and Neighborhood Health Plan of Rhode Island, pursuant to requirements of the Rhode Island Health Care Reform Act of 2004: The Lewin Group, Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: Blue Cross Blue Shield of Rhode Island (August 11, 2006); The Lewin Group, Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: United HealthCare of New England (August 11, 2006); The Lewin Group, Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: Neighborhood Health Plan of Rhode Island (August 11, 2006), *available at* http://www.dbr.state.ri.us/divisions/healthinsurance/.

[75] RCW § 48.43.335

stronger public understanding of carrier operations and, such additional public scrutiny may push carriers to improve efficiency and carrier operations.

The state has already begun specific efforts focused on transparency. Last year the legislature enacted the bill, HB 2500. It provides a method of reporting certain health carrier financial data in a format easier to read and understand.[76] This year, as part of the Washington Insurance Commissioner's focus on transparency, the Commissioner has proposed a Market Analysis Program (draft Z-0179), which would create a market conduct oversight program that replaces the existing program. This new program would provide the OIC with the necessary information and methods needed to monitor the state's insurance marketplace, and identify trends.[77] We recommend using such analysis in any type of rate regulation review and approval as well.

Any regulatory action to improve transparency amongst health carriers must not impose excessive reporting requirements. Otherwise, the goal of transparency will have the unintended consequence of increasing administrative costs and reducing health carrier efficiency.

Community Benefit Requirements

Another interesting legislative action in Rhode Island was the reorganization of the board of directors of BCBSRI so that the Governor, the Speaker of the House and the President of the Senate were each given the authority to appoint two directors to the Blue Cross board. Thus, a total of six of sixteen Blue Cross board members are public appointees, and each may serve up to three consecutive 3-year terms. None of the six public appointees may be licensed health care professionals. In addition, the new law calls for vacancies in the remaining, non-publicly appointed board seats to "be filled by an open and public process" that shall "include public solicitation."[78] The Rhode Island Medical Society had pushed the legislature to pass this statute "to help return it to its vital community mission."[79]

Restructuring a non-profit's Board can push a non-profit carrier to focus more strongly on improving access, premium affordability and other community benefits. Other states have chosen different mechanisms to focus on these issues. Some states have worked with large non-profit carriers in directing high surpluses toward community benefit health care initiatives. For example, Massachusetts has created formal community benefit guidelines for non-profit HMOs in the state. Also, Pennsylvania formalized the prospective "community activities" of its four Blue Cross Blue Shield Plans and the plans voluntarily agreed to commit $150 million annually

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[76] RCW § 48.43.049; Currently, health carriers in the State of Washington are required to file statutory annual statements with either the National Association of Insurance Commissioners (NAIC) or the State of Washington Office of the Insurance Commissioner. These statements are extensive and contain a significant amount of financial information. These statements are also public documents, although the information included in the statements can often be complex and difficult to read and understand.

[77] State of Washington, Office of the Insurance Commissioner, Legislative Agenda, (September 2006).

[78] Newsletter of the Rhode Island Medical Society, Rhode Island Medical News (July/August 2004) Vol. XVII No.3. It is important to note that when the bill was first heard to restructure the BCBSRI Board, the state was looking to gain stronger control of BCBSRI's Board. However, BCBSRI raised the issue of losing Blue Cross Blue Shield licensure with the loss of Board control. Therefore, the State was limited to six government-appointed Board members out of a total of sixteen total Board members.

[79] *Ibid.*

to a six-year community health reinvestment program. This program included $85 million to support basic health coverage for low-income and uninsured residents with the remaining $65 million for other health care related community activities.[80]

Most recently, CareFirst announced a $92 million initiative intended to address community benefit with $60 million from a reduction in premiums against anticipated 2005 levels. This was in response to increased public scrutiny, especially by the Appleseed Foundation and hearings by the DC Insurance Commissioner on CareFirst BlueCross BlueShield's D.C. affiliate, Group Hospitalization and Medical Services, Inc.'s (GHMSI) charitable obligation to the community. [81]

It is important to note that while CareFirst's charter includes "charitable and benevolent" language, the charters for Regence and Premera do not.[82] Nevertheless, the D.C. Attorney General did not find that such language created an obligation for GHMSI to use its profits and excess surplus for charitable purposes. Rather, the Attorney General indicated that the decision as to how GHMSI will use its profits and excess surplus to serve the needs of its subscribers or the public is a decision for its Board. Specifically, the Attorney General, in a March 4, 2005 legal memorandum, rejected one of Appleseed's main contentions, concluding that, "GHMSI does not have an obligation ... to satisfy any minimum threshold for providing services at no charge or for making contributions to other organizations. Within the constraints imposed by GHMSI's charter, the decision as to how GHMSI will use its profits and excess surplus to serve the needs of its subscribers or the public is largely up to its board." The Attorney General indicated that the D.C.-based Blues Plan can meet its "charitable and benevolent" charter obligations by "maximizing the quality, benefits, affordability and accessibility of its health plans." He wrote that GHMSI has no legal obligation to spend any specific amount of money on public health or similar charitable activities. Appleseed, in its report, had argued that GHMSI is obligated to spend between 2 percent and 3 percent of its annual premium revenues on "charitable community benefit activities," or between $41 million and $61 million annually. Thus, we see from the CareFirst example how public hearings on the issues of community benefit and premium rate reductions can push carriers to voluntarily reduce premiums and implement community benefit initiatives while ensuring that health carrier solvency is not in jeopardy.

Finally, we note that the unintended consequence of imposing community benefit requirements on non-profit carriers is that such requirements serve as an indirect tax on carrier members, who subsidize community benefit initiatives of the carrier with their premiums. Some members prefer a reduction in premiums instead of using premium profits for community benefit initiatives, which serve the community as a whole.

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80 "Health Insurance Premiums, the Underwriting Cycle, and Carrier Surpluses," Maryland Health Care Commission, (March 2005).

81 "CareFirst Affiliate, GHMSI, Pledges to Improve Affordability of Insurance, Expand Charitable and Community Investments" CareFirst Blue Cross Blue Shield press release, (March 24, 2005) *available at* http://www.carefirst.com/media/NewsReleasesDetails/NewsReleasesDetails_20050324.html.

82 However, GHC does have such language in its charter.

VI. CONCLUSION

In conclusion, there are a myriad of ways to regulate surplus, each with its own intended and unintended consequences. Focusing on increased transparency can improve competition, efficiency and stronger regulatory authority and oversight can provide the first step in addressing concerns of surplus accumulation. The next step can be some form of regulatory action such as rate regulation or implementing guidelines on non-profit carrier community benefit requirements, but neither should be implemented in a vacuum.

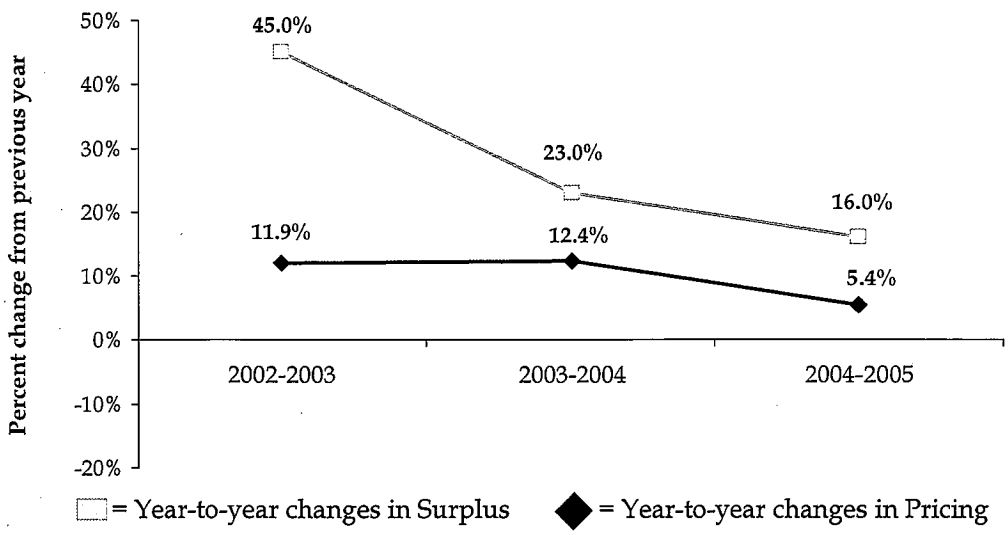
Based on our initial, high-level assessment, the OIC should consider examining the surplus levels of at least the three largest Washington carriers: Regence, Premera and GHC to assess whether they are appropriate to meet current and future business and risk management needs. This issue potentially takes on added urgency in the face of any regulatory action of the Commissioner in the upcoming legislative session (such as draft Z-0152 which would provide the Commissioner with explicit authority to consider carrier surplus when reviewing rates) as such action could significantly affect surplus levels. As is the case with any new regulatory action, new requirements could create new financial risks and increase uncertainty around surplus demand. To avoid any regulatory action having the unintended consequence of reducing surplus of carriers that are undercapitalized, we suggest the appropriateness of conducting a surplus target range review.

Targeting appropriate surplus levels is critical for managing financial risk. It is even more important for non-profit organizations which do not have access to equity markets and must fund investments in new products and infrastructure out of operating results, surplus or debt instruments. Surplus levels which are held too low expose the organization to risk of failure during predictable periods of downturns in the underwriting cycle. They also limit the organization's ability to respond to changes in business conditions and demands for new products. Surplus levels which are too high may affect product affordability and subject the organization to unwanted regulatory scrutiny. Since most states do not impose maximum surplus levels, it is incumbent on state insurance departments to review these issues in light of the context and critical considerations for conducting a surplus review discussed throughout this report.

Appendix A
Trends in Pricing and Surplus:

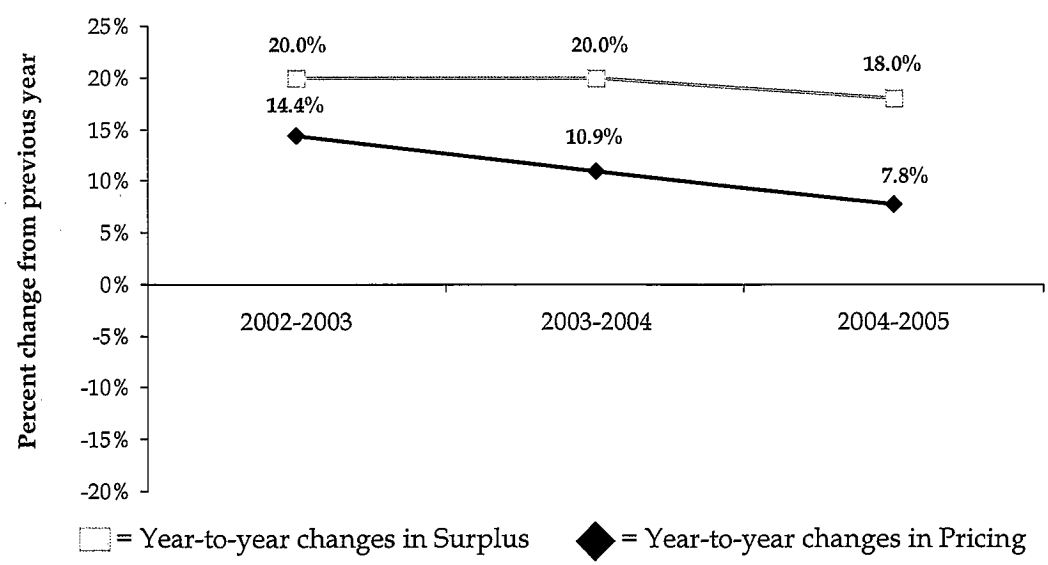
Trends in Pricing and Surplus: 2002-2005

Regence Year-to-Year Changes In Pricing Vs. Surplus
(all commercially insured products)



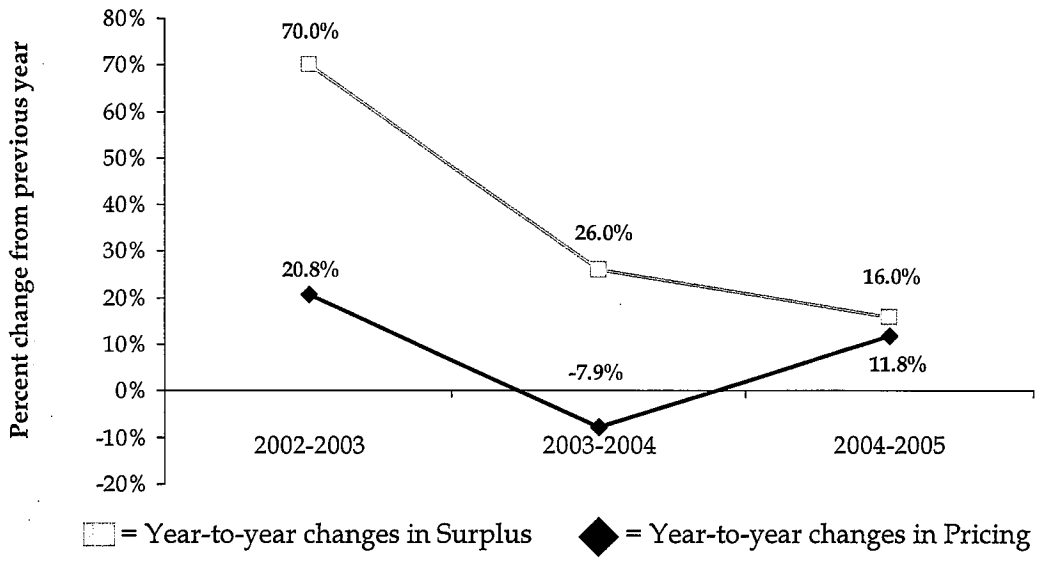
Notes: Lewin Analysis.
2002 - 2005 Annual Statements, WA OIC website:
<https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp>

Premera Year-to-Year Changes In Pricing Vs. Surplus
(all commercially insured products)



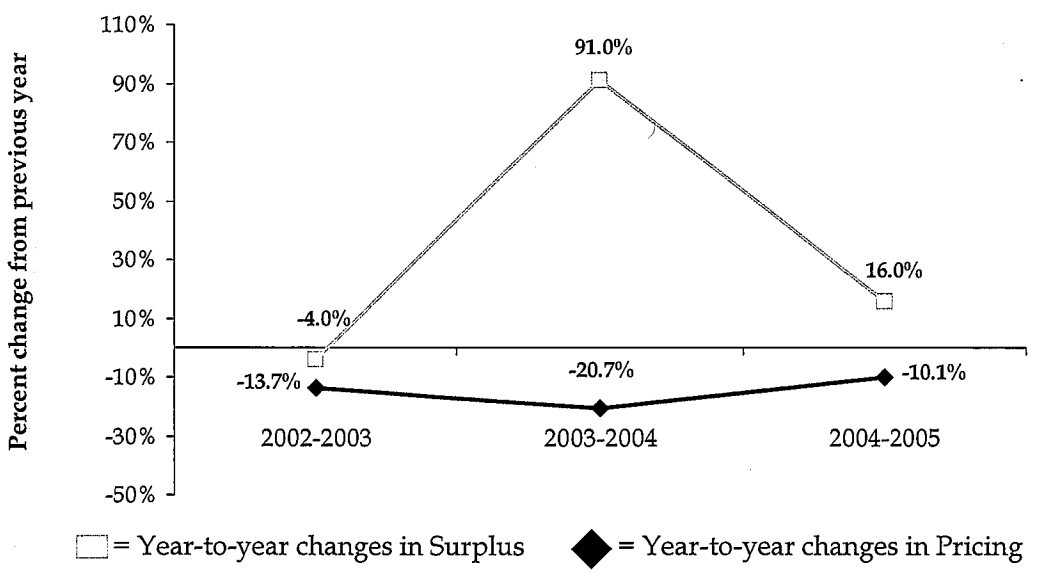
Notes: Lewin Analysis.
2002 - 2005 Annual Statements, WA OIC website:
<https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp>

Group Health Cooperative Year-to-Year Changes In Pricing Vs. Surplus
(all commercially insured products)



Notes: Lewin Analysis.
2002 - 2005 Annual Statements, WA OIC website:
<https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp>

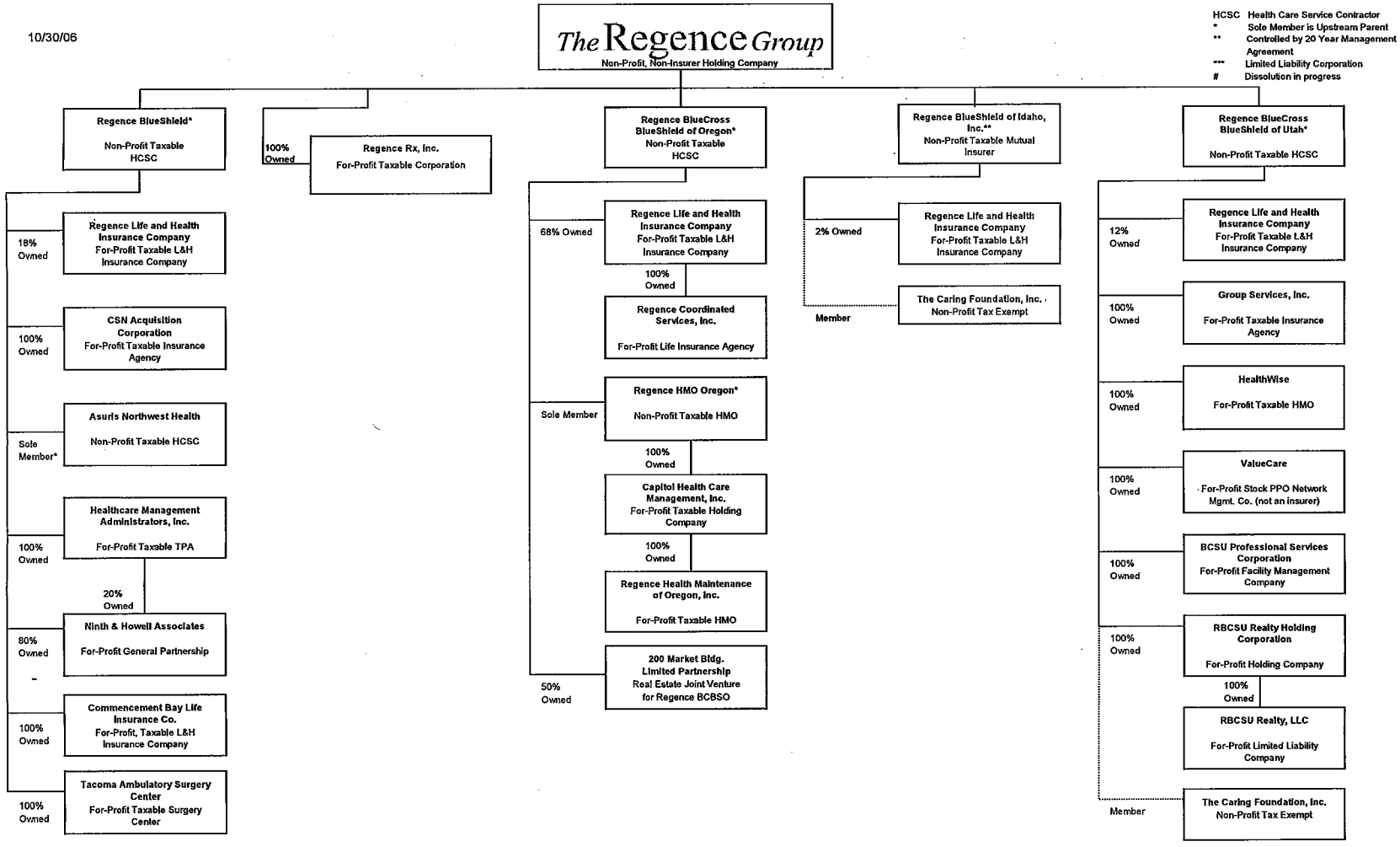
PacifiCare Year-to-Year Changes In Pricing Vs. Surplus
(all commercially insured products)

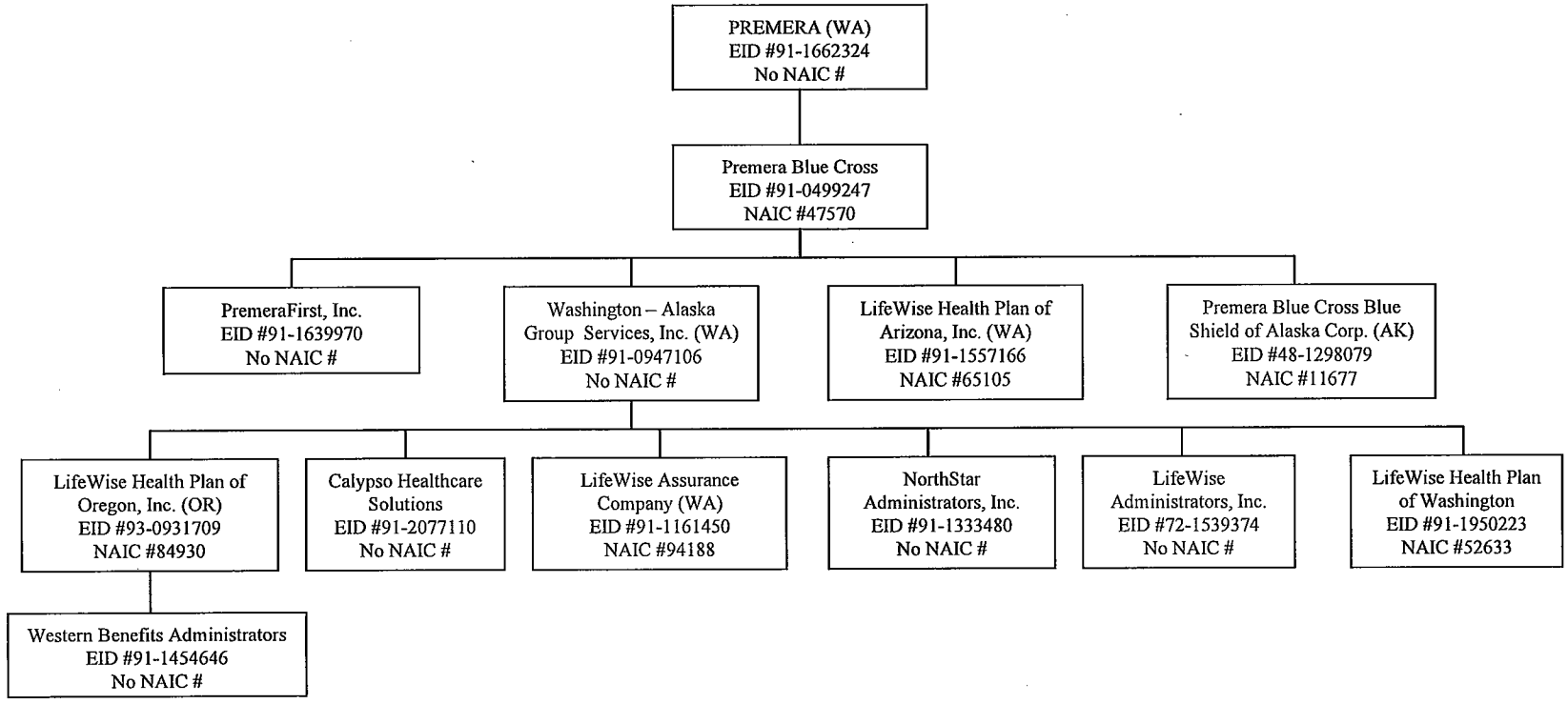


Notes: Lewin Analysis.
2002 - 2005 Annual Statements, WA OIC website:
<https://fortress.wa.gov/oic/annrptpublic/AnnRptPublicClient/AnnRptPublicClient.asp>

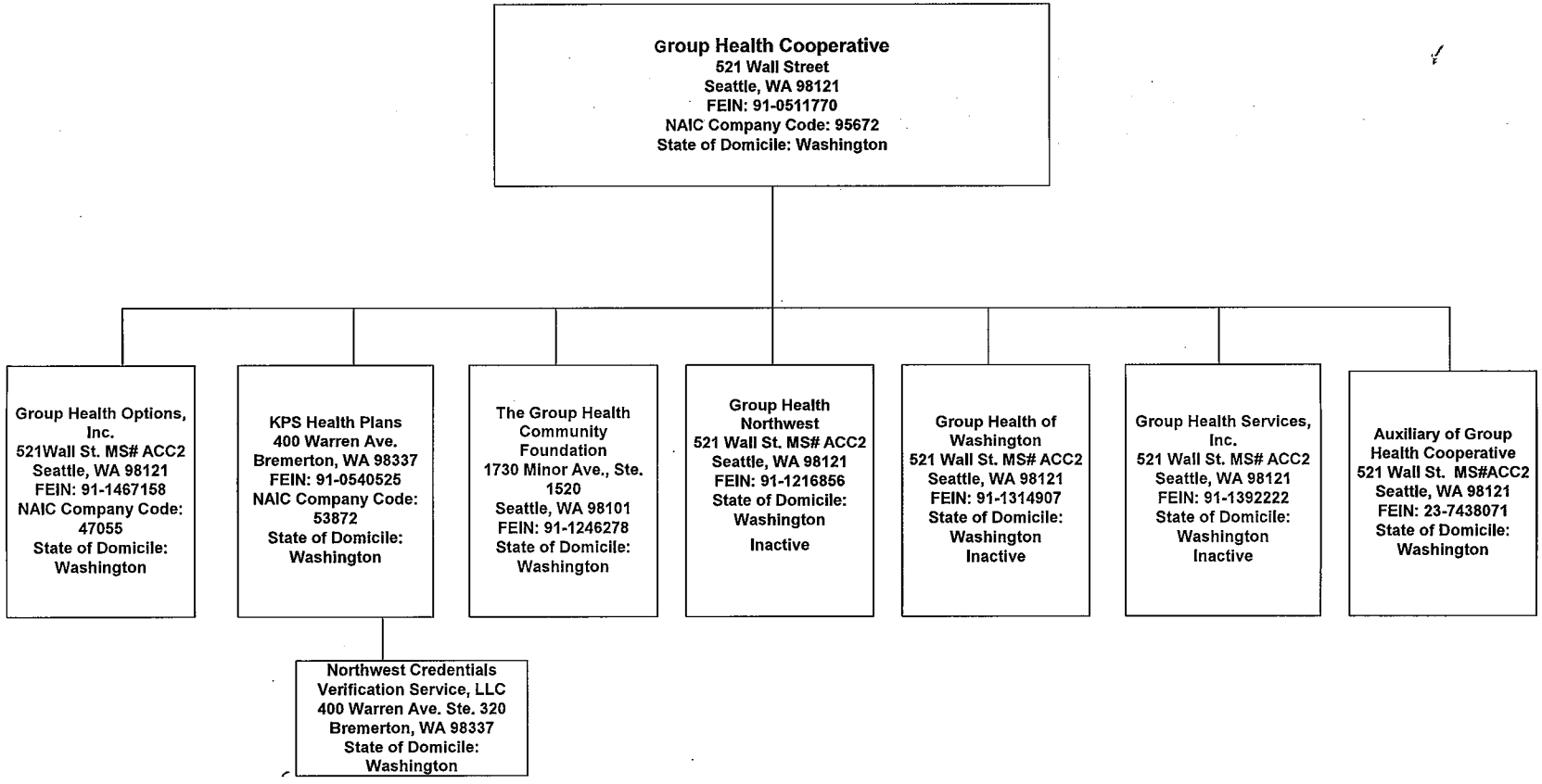
Appendix B
Health Carrier Organizational Charts:

10/30/06


The Regence Group
Non-Profit, Non-Insurer Holding Company
HCSC Health Care Service Contractor
* Sole Member is Upstream Parent
** Controlled by 20 Year Management Agreement
*** Limited Liability Corporation
# Dissolution in progress
Regence BlueShield*
Non-Profit Taxable HCSC
100% Owned
Regence Rx, Inc.
For-Profit Taxable Corporation
Regence BlueCross BlueShield of Oregon*
Non-Profit Taxable HCSC
Regence BlueShield of Idaho, Inc.**
Non-Profit Taxable Mutual Insurer
Regence BlueCross BlueShield of Utah*
Non-Profit Taxable HCSC
18% Owned
Regence Life and Health Insurance Company
For-Profit Taxable L&H Insurance Company
68% Owned
Regence Life and Health Insurance Company
For-Profit Taxable L&H Insurance Company
2% Owned
Regence Life and Health Insurance Company
For-Profit Taxable L&H Insurance Company
12% Owned
Regence Life and Health Insurance Company
For-Profit Taxable L&H Insurance Company
100% Owned
CSN Acquisition Corporation
For-Profit Taxable Insurance Agency
100% Owned
Regence Coordinated Services, Inc.
For-Profit Life Insurance Agency
Member
The Caring Foundation, Inc.
Non-Profit Tax Exempt
100% Owned
Group Services, Inc.
For-Profit Taxable Insurance Agency
Sole Member*
Asuris Northwest Health
Non-Profit Taxable HCSC
Sole Member
Regence HMO Oregon*
Non-Profit Taxable HMO
100% Owned
HealthWise
For-Profit Taxable HMO
100% Owned
Healthcare Management Administrators, Inc.
For-Profit Taxable TPA
100% Owned
Capitol Health Care Management, Inc.
For-Profit Taxable Holding Company
100% Owned
ValueCare
For-Profit Stock PPO Network Mgmt. Co. (not an insurer)
20% Owned
100% Owned
Regence Health Maintenance of Oregon, Inc.
For-Profit Taxable HMO
100% Owned
BCSU Professional Services Corporation
For-Profit Facility Management Company
80% Owned
Ninth & Howell Associates
For-Profit General Partnership
50% Owned
200 Market Bldg. Limited Partnership
Real Estate Joint Venture for Regence BCBSO
100% Owned
RBCSU Realty Holding Corporation
For-Profit Holding Company
100% Owned
Commencement Bay Life Insurance Co.
For-Profit, Taxable L&H Insurance Company
100% Owned
RBCSU Realty, LLC
For-Profit Limited Liability Company
100% Owned
Tacoma Ambulatory Surgery Center
For-Profit Taxable Surgery Center
Member
The Caring Foundation, Inc.
Non-Profit Tax Exempt



Note: each subsidiary shown above is 100% owned by its respective parent company.


Group Health Cooperative
521 Wall Street
Seattle, WA 98121
FEIN: 91-0511770
NAIC Company Code: 95672
State of Domicile: Washington
Group Health Options, Inc.
521Wall St. MS# ACC2
Seattle, WA 98121
FEIN: 91-1467158
NAIC Company Code: 47055
State of Domicile: Washington
KPS Health Plans
400 Warren Ave.
Bremerton, WA 98337
FEIN: 91-0540525
NAIC Company Code: 53872
State of Domicile: Washington
Northwest Credentials Verification Service, LLC
400 Warren Ave. Ste. 320
Bremerton, WA 98337
State of Domicile: Washington
The Group Health Community Foundation
1730 Minor Ave., Ste. 1520
Seattle, WA 98101
FEIN: 91-1246278
State of Domicile: Washington
Group Health Northwest
521 Wall St. MS# ACC2
Seattle, WA 98121
FEIN: 91-1216856
State of Domicile: Washington
Inactive
Group Health of Washington
521 Wall St. MS# ACC2
Seattle, WA 98121
FEIN: 91-1314907
State of Domicile: Washington
Inactive
Group Health Services, Inc.
521 Wall St. MS# ACC2
Seattle, WA 98121
FEIN: 91-1392222
State of Domicile: Washington
Inactive
Auxiliary of Group Health Cooperative
521 Wall St. MS#ACC2
Seattle, WA 98121
FEIN: 23-7438071
State of Domicile: Washington

Attachment A

Comments by PacifiCare of Washington

PacifiCare of Washington
Comments to Lewin Group Washington Surplus Report
Page 28 and 29 ALR and Admin PMPM foot note:

The data used in these graphs represent total administrative expense, total revenue and total membership. Because PacifiCare of Washington's business concentration is in the Medicare line of business and since Medicare premium is in general 3 times higher than commercial premium, this business relationship is responsible for the disparity between the ALR and the Admin PMPM as illustrated by the following table:

	Medicare Advantage	
	Members as a %	Premium as a %
2001	44.0	71.5
2002	46.9	72.7
2003	44.5	69.1
2004	46.4	69.9
2005	57.9	77.6

Page 38 Historical Pricing Values

PacifiCare of Washington, Inc.'s line of business details as presented in the statutory financial statements (exhibit name *Additional Data to Annual Statement for the Year Ending)* was inaccurate for the years ended December 31, 2002 and 2003. While the total is correct, the line of business presentation of individual, small group, large group and Public Employees Benefit Board was inconsistent in the years presented. The correct information for those years is as follows:

	Small Group			
	Reported		Correctly Stated	
	Memb. Months	Premium	Memb. Months	Premium
2002	69,354	3,008,302	67,680	12,487,427
2004	230,304	7,406,802	157,863	32,961,181

The correct small group average premium for 2002 and 2004 was $184.51 and $208.80 respectively, which are in line with other years reported.

Page 39 Historical Profit Margins Values

In this graph 2002 is incorrectly reflected as profit when it actually was reported as $12 million underwriting loss. It should be a negative 12%.

Page 40 Historical Pricing Values

PacifiCare of Washington, Inc.'s line of business details as presented in the statutory financial statements (exhibit name *Additional Data to Annual Statement for the Year Ending)* was inaccurate for the years ended December 31, 2003 and 2005. While the total is correct, the line of business presentation of individual, small group, large group and Public Employees Benefit Board was inconsistent in the years presented. The correct information for those years is as follows:

Large Group

	Reported		**Correctly Stated**	
	Memb. Months	**Premium**	**Memb. Months**	**Premium**
2003	318,287	56,406,497	189,855	40,318,363
2005	318,763	38,994,630	269,439	57,240,443

The correct large group average premium for 2003 and 2005 was $212.36 and $252.32 respectively, which are in line with other years reported.

Attachment B

Comments by Premera Blue Cross

PREMERA | BLUE CROSS

Via E-Mail and First-Class Regular Mail

January 19. 2007

Nalini K. Pande, *Nalini.Pande@Lewin.com*
Senior Manager
The Lewin Group
3130 Fairview Park Dr., Suite 800
Falls Church, VA 22042

Melodie Bankers, *melodieb@oic.wa.gov*
Senior Policy Advisor,
Office of the Insurance Commissioner
Policy Division
P. O. Box 40258
Olympia, WA 98504-0258

Re: Comments on Draft Policy Options Regarding Surplus Accumulation

Dear Ms. Bankers and Ms. Pande:

Attached are the comments of Premera Blue Cross (including LifeWise Health Plan of Washington) on the draft *Policy Options Regarding Surplus Accumulation in the Washington Health Insurance Market* prepared for the Washington Office of the Insurance Commissioner ("OIC"), dated December 11, 2006. We appreciate the opportunity to share our suggestions and sincerely hope that you will give them full consideration in preparation of the final report. We would be happy to discuss our suggestions with you.

Very truly yours,

John H. Pierce
Special Counsel

Comments of Premera Blue Cross on draft *Policy Options Regarding Surplus Accumulation in the Washington Health Insurance Market,* dated December 11, 2006, prepared by The Lewin Group

January 19, 2007

Executive Summary

The Lewin Group ("Lewin") was asked by the Washington Office of the Insurance Commissioner ("OIC") to review the issue of "surplus" in connection with concerns about addressing the issue of affordability of health care. Specifically, Lewin was asked to determine a standard for determining whether a health plan has "excess surplus", and, if there is a standard, how any such "excess surplus" should be regulated.

Lewin has identified significant adverse consequences of artificial limitations on surplus. Premera Blue Cross ("Premera") strongly believes that the recommendation of further study of the surplus levels of only three plans in the state is inconsistent with the factual findings of Lewin's report (the "Draft Report"). We ask that the Draft Report be modified to take into account the following:

- The Draft Report concludes that there is not an accepted objective standard for determining or regulating "excess surplus". The Draft Report identified only three states, Pennsylvania, Michigan and New Hampshire, that regulate the upper limits of accumulated surplus. One other state, Hawaii, previously enacted legislation regulating upper limits of surplus, but that legislation expired and has not been reenacted. Washington would therefore become an outlier state should it pass legislation regulating "excess surplus" of a health plan. Since this finding of no existing standard is a conclusive response to the OIC's inquiry, the recommendation should be that regulation of or limits on surplus are not appropriate;

- Regulation of accumulation of surplus does not address the fundamental issue of the cost of health care, the purported objective of your inquiry. Rather, regulation of surplus amounts to artificial rate suppression, which is not a legitimate or sustainable strategy for cost reduction. Indeed, as pointed out in the Draft Report, rate suppression leads to market disruption and other adverse consequences;

- In Washington State, Governor Christine Gregoire, through her Blue Ribbon Commission on Health Care Costs and Access, is addressing affordability of and access to health care, that is purportedly a concern addressed by the Draft Report. The Blue Ribbon Commission has recognized the need to address the cost of care and has not endorsed rate regulation as a solution; and
- The Draft Report notes that Washington is already one of the most highly regulated states, which limits competition. Regulation of surplus creates limitations on carriers' flexibility and increased financial risk, which will exacerbate the problem of affordability and access.

In summary, we believe that the factual findings of the Draft Report do not support regulation of surplus. The recommendation to further examine the surplus of a limited number of insurers—which implicitly suggests that their surplus should be regulated—is inconsistent with the findings of the Draft Report. In particular, the data in the Draft Report on the profitability of individual products, is not an accurate representation of the profitability of the Premera family of companies individual product lines. We ask that that data be corrected in accordance with the attachments.

We also note that the Draft Report has material errors or mischaracterizations which should be corrected. Those items are compiled in Appendix A attached.

Background

The OIC has an express statutory obligation to ensure that health plans remain solvent. There are established objective standards and processes by which this obligation is carried out. Regulation of or limits on the upper limits of a plan's reserves is at least inconsistent with, if not contrary to, that obligation.

As we previously pointed out to the OIC, in our testimony in December 2005 and letter dated December 9, 2005, in 1998 the Washington State Legislature passed legislation establishing risk-based capital ("RBC") standards for health carriers. The legislation was crafted to conform closely to the model act adopted by the National Association of Insurance Commissioners ("NAIC") the same year. Both the model act and the state law direct the Insurance Commissioner to ensure minimum levels of capital to protect policyholders against company insolvency. Our current state law declares explicitly that "excess" capital is desirable:

> An excess of capital over the amount produced by the risk-based capital requirements contained in RCW 48.43.300 through 48.43.370 and the formulas, schedules, and instructions referenced in RCW 48.43.300 through 48.43.370 is desirable in the business of insurance. Accordingly, carriers should seek to maintain capital above the RBC levels required by RCW 48.43.300 through 48.43.370. Additional capital is used and useful in the insurance business and helps to secure a carrier against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in RCW 48.43.300 through 48.43.370.

In addition, the NAIC model and state law further clarify that RBC was not designed nor intended to address how much capital is good, better or best.

> It is further the judgment of the legislature that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurances that a health organization or any affiliate is authorized to write.

In its proceedings, the NAIC working group that developed the RBC model act "discussed problems with using RBC results to other purposes," saying the formula "was not developed to measure financial strength or capital adequacy beyond a minimum requirement. . . has not been designed to differentiate among adequately capitalized Companies . . . [and] . . . it would be entirely inappropriate to use this formula to rate or rank adequately capitalized companies.

As we previously pointed out, the paramount and most obvious need for capital reserves for Premera or any other health carrier is the protection of the policyholders. Once minimum solvency requirements are met, Premera's next need is to ensure that we add to our reserves at the same rate as the medical care cost trend, which is rising several times faster than inflation. Operating income is the primary source on which non-profit companies rely to build their capital base. We are challenged to accomplish this growth while operating in an environment of very thin profit margins. Although in 2005, Premera realized an underwriting gain of 2.9%, our cumulative 10-year underwriting gain as of 2005 is only 0.6%, less that 1%.

The challenge of building and maintaining capital is compounded by the effects of the underwriting cycle. You have previously noted that over the last 40 years, Blue Cross Blue Shield companies have had 3 to 6 years of underwriting profit followed by a down cycle of similar length. Insurers must build their capital reserves when they can to offset periods of operating losses. Experts from Global Insights, the former Data Resources Inc. and Wharton Econometrics Associates, predict that carriers are now entering a new down cycle, and profits are due to erode in the coming years.[1] In spite of thin margins and the cyclical nature of insurance, building capital reserves has been a corporate priority for Premera. We have made significant progress over the past several years. In the late 1990s, following several years of losses for Premera, our capital reserves were in the high 400% range, more than double the regulatory action level. But even so, in 1997 the OIC, including current senior officials of the OIC, approached Premera with concerns about whether we were sufficiently capitalized. During the profitable stage of the underwriting cycle Premera improved its RBC capital to 560% at the end of 2005. As of the end of 2004, total capital reserves were about $618 for each of our 837,000 insured members. For illustrative purposes, one additional emergency room visit for each of our members at a cost of about $600 per visit would deplete our current capital reserves.

Current Evaluation

Now, apparently in response to advocacy by certain special interests due to the cost of health insurance and based on unspecified and vague concerns about recent contributions to health plans reserves, the OIC has asked Lewin to evaluate:

- whether Washington's domestic carriers have "excess surplus";
- if so, how that term should be defined; and
- if so, how such "excess surplus" should be regulated. Draft Report, p. 1.

The predicate finding required to respond to the OIC's inquiries is whether there is such a thing as an inappropriately high level of reserves—if not, the remainder of the inquiry becomes moot.

The Draft Report's recommendation is that ". . . *the OIC should consider examining the surplus levels of at least the three largest Washington carriers: Regence, Premera, and GHC to assess whether they are appropriate to meet current and future business and risk management needs.*" (the "Recommendation"). Draft Report, p. 46[2]. As such, the Draft Report fails to address the fundamental issue of what level of surplus is appropriate. The apparent reason for this failure is the admitted lack of any agreement among experts regarding a definition of or standard for "excess surplus".[3] Therefore, the response to the OIC's inquiries would more properly be: "There is no definition of "excess surplus", so whether Washington's domestic carriers have such a thing cannot be determined and there is no basis for regulation". The Recommendation indeed begs the question of were the OIC to conduct the suggested examination, what standard would be applied in determining whether surplus levels are appropriate. The standard seems to be a "we'll

[1] David Eli, "U.S. Health Insurance Underwriting Cycle Set for a Downturn", Global Insights. [2] The Draft Report does not explain why the Recommendation is limited to review of [only health carriers, specifically] Premera, Regence and Group Health. We are not aware of any basis for such selective regulatory enforcement. [3] The level of surplus required to provide an adequate margin of safety is a matter of judgment, and experts do not agree on a "right" or "correct" target surplus level for a health carrier. Draft Report, pp. 1, 17.

know it when we see it" approach, which is obviously inappropriate as a regulatory standard.[4]

The Draft Report is a thorough discussion of many of the issues relating to surplus levels. For example, the discussion of the issues, advantages and "unintended consequences" (which for the most part are "disadvantages") does identify potential benefits and risks of a particular policy option. However, the Draft Report does not conduct any sort of reasoned balancing of the potential benefits and risks to arrive at the Recommendation. For example, under the policy option of "Capping Surplus", the Draft Report identifies the potential disadvantage of forcing competitors to leave the market. Draft Report, p. 2. However, it does not quantify the likelihood or magnitude of that effect[5], nor does it compare it to any possible benefits.[6] Also by way of example, the Draft Report acknowledges that the uncertainty of future regulatory action contributes to limits on carrier flexibility and increases financial risk. Draft Report, p. 6. As a third example, the Draft Report recognizes that non-profit carriers (such as those treated in the Recommendation) do not have the option available to for-profit carriers of raising cash from equity markets, so have to rely on surplus accumulation for contingencies over a longer time. However, there is no suggestion of how that limitation should impact any regulatory action. The Draft Report recognizes that nonprofit carriers have a need to maintain higher capital levels and limited sources of capital. Therefore, the Recommendation – to study the surplus of three nonprofit companies with a possible view to regulating the capital of those companies – is inconsistent with those Lewin findings. So the Recommendation would lead to at least three admitted adverse consequences to carriers, but does not quantify the likely adverse consequences.[7] Thus, there does not seem to be any logical basis to draw conclusions about what policy options might be viable for Washington. In the end, this may be the reason for the inconclusive and subjective Recommendation.

Conclusion

In summary, we ask that you withdraw or modify the draft report as requested and instead issue a report that makes clear your position that there is not an objective basis for setting upper limits on surplus and that subjective regulation of insurers in this state would be inappropriate.

[4] The Draft Report recognizes that "health insurance is very competitive and typically produces relatively small margins". Draft Report, p. 15. This seems to be an admission that the market works effectively in regulating the carriers "margin" and contradicts the need for a regulatory intervention—particularly one based on a subjective analysis.

[5] This particular omission stands out since, as the Draft Report points out, Washington lost all carriers from the individual market due to overregulation in the late 1990s. The Draft Report points out that less competition can result in less choice for consumers, pricing disruptions and greater risk to the carriers. Draft Report, pp. 2, 5.

[6] Indeed, the Draft Report's conclusion refers only to "a myriad of ways to regulate surplus, each with its own intended and unintended consequences", without analysis of the likely impact of any of those regulatory actions.

[7] The Draft Report also recognizes various risks for carriers in Washington due to regulatory requirements and a large number of benefit mandates and greater risks for regional carriers versus national carriers (Draft Report, p. 6). Additional regulation as proposed by the OIC would only serve to increase this risk and the possibility of market disruption.

Appendix A

The Draft Report includes four case studies relating to the consequences of lack of reserves, including one health plan in Washington (KPS Health Plans). It avoids a discussion of the other domestic health carriers who no longer exist in part due to solvency concerns. We believe a fair treatment of the risk to carriers in this state would include an analysis of the reasons those plans no longer exist.

The Draft Report generally adopts a tone casting carriers in a negative light. For example, the Draft Report refers to the sunset of the Hawaii law relating to limitations on net worth, and indicates that the law was not extended due to health plan opposition. Draft Report, p. 19. It would be more appropriate to indicate legislation was not passed to extend the law due to the decision of the legislature. As another example, in referring to the 2000 health reform legislation in Washington, the Draft Report states that the "Governor struck a deal" with the health carriers" and that "[f]urther, State lawmakers passed legislation . . ." reforming the market. Draft Report, p. 34. While the Governor and the health carriers did reach an agreement, it would be more appropriate to state that the legislature amended existing law in an effort to revitalize the individual health insurance market. On that same topic, the Draft Report states that "The carriers cited adverse selection for their decisions [to leave the market]". Draft Report, p. 34. This mischaracterizes the fact that the carriers were collectively losing tens of millions of dollars, in part due to the very type of rate regulation presently promoted by the OIC. We ask that you delete these and other misleading or negative references about health plans from your report.

Page 29 identifies the 2005 Admin PMPM for Premera at $19. This value is incorrect, because the wrong line from the Annual Statement was used. This value should be shown as $16 PMPM, based on using line number 21 (General Administrative Expenses) rather than line number 20 (Claims Adjustment Expenses) on Page 4 (Statement of Revenue and Expenses) of the Annual Statement. This matches the calculation used by Lewin for other plans.

Page 40 identifies the 2005 Avg. Monthly Premium for Premera at $269, which is presented on a PMPM basis. This value is incorrect, and should be shown as $261, based on using the Total Revenue line (line 7 on the Additional Statement Form, Analysis of the Washington Comprehensive Line, 2005 Annual Statement), thus reducing the premiums for experience rated refunds, as Lewin did for other plan values, rather than using the Net Premium Income line (line 1 on the same report).

The charts on pages 35 and 36 distort Premera's results for the individual market because they both treat Premera and LifeWise Health Plan separately. In fact, Premera's individual line of business in Washington is provided through both entities. The Premera individual products are not actively marketed, resulting in skewed financial results which cannot appropriately be compared to the results of other plans. Similarly, the sentence on page 36 beginning "There appears to have been a positive correlation . . ." should be reconsidered based on a comparison of values excluding the Premera individual line of business. We ask that you modify these two charts and conclusion to combine the results of Premera and LifeWise. Attached is a table and two charts demonstrating the difference between the array of Premera and LifeWise results separately, and as combined.

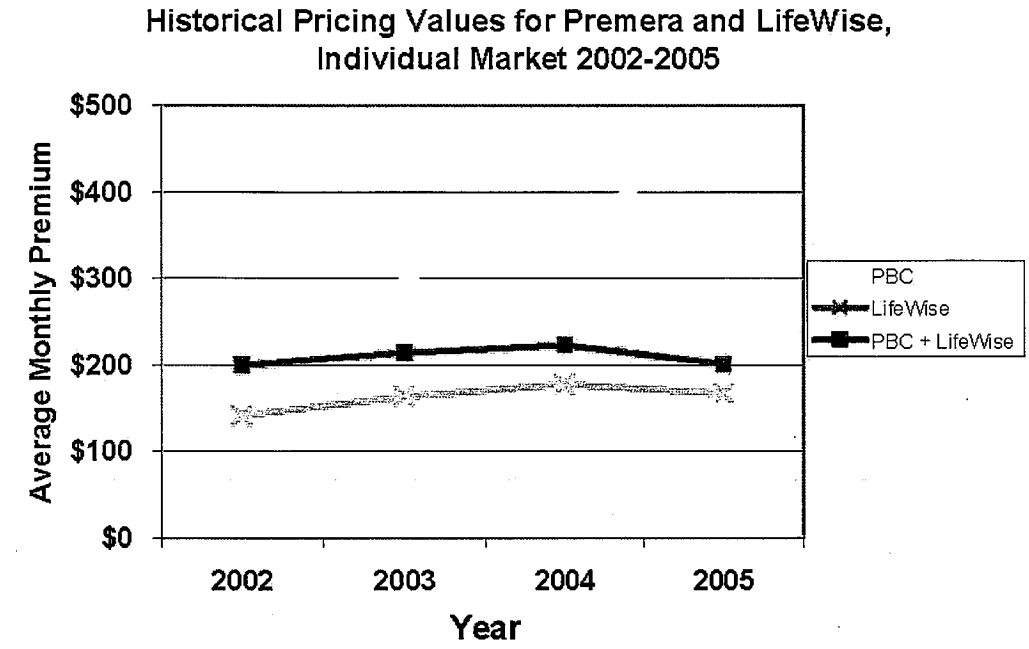
Response to Lewin Report on Accumulation of Surplus Summary of PBC Individual and LifeWise of Washington Individual

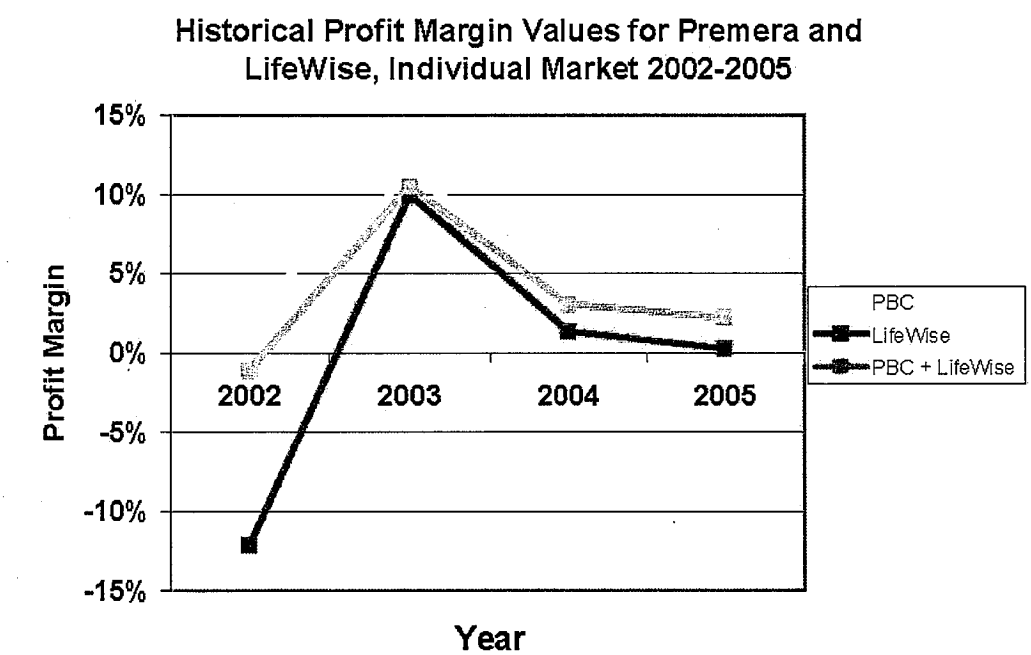
	2002	2003	2004 2005
PBC Individual			
Member Months	495,082	314,411	203,351 132,643
Revenue Net	$116,205,280	$93,502,308	$75,679,215 $58,672,410
Underwriting Gain	$3,323,985	$10,278,648	$4,339,575 $4,356,524
PMPM Premium Profit	$234.72 2.9%	$297.39	$372.16 $442.33 5.7% 7.4%
as % Revenue		11.0%	
LifeWise Individual			
Member Months	292,428	510,919	664,489 930,013
Revenue Net	$41,576,332	$83,694,745	$118,237,481 $155,247,479
Underwriting Gain	($5,041,927)	$8,371,945	$1,623,037 $407,878 $177.94
PMPM Premium Profit	$142.18	$163.81	$166.93 1.4% 0.3%
as % Revenue	-12.1%	10.0%	
PBC + LifeWise Combined			
Member Months	787,510	825,330	867,840 1,062,656
Revenue Net	$157,781,612	$177,197,053	$193,916,696 $213,919,889
Underwriting Gain	($1,717,942)	$18,650,593	$5,962,612 $4,764,402
PMPM Premium Profit	$200.36 -1.1%	$214.70	$223.45 $201.31 3.1% 2.2%
as % Revenue		10.5%	

Summary for Charts

Avg Premiums	2002	2003	2004 2005 $372.16
PBC LifeWise	$234.72	$297.39	$442.33 $177.94 $166.93
PBC + LifeWise	$142.18	$163.81	$223.45 $201.31
	$200.36	$214.70	

Profit Margin	2002	2003	2004 2005 5.7% 7.4%
PBC LifeWise	2.9% -	11.0%	1.4% 0.3% 3.1% 2.2%
PBC + LifeWise	12.1%	10.0%	
	-1.1%	10.5%	


Historical Pricing Values for Premera and LifeWise, Individual Market 2002-2005
$500
$400
$300
$200
$100
$0
Average Monthly Premium
2002
2003
2004
2005
Year
PBC
LifeWise
PBC + LifeWise


Historical Profit Margin Values for Premera and LifeWise, Individual Market 2002-2005
15%
10%
5%
0%
-5%
-10%
-15%
Profit Margin
2002
2003
2004
2005
Year
PBC
LifeWise
PBC + LifeWise

Attachment C

Comments by Regence Blue Shield

Regence BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

January 18, 2007

Via e-mail and US Postal Service

Ms. Melodie Bankers, JD
Senior Health Policy Advisor
Office of the Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504-0258

Dear Ms. Bankers:

Thank you for the opportunity to provide comments on the draft of the Lewin Group's report, "Policy Options Regarding Surplus Accumulation in the Washington Health Insurance Market." In general we appreciate the tone and content of the report. Following are a few specific comments and/or corrections.

1) We agree with Lewin's conclusion that no one RBC number fits all companies. (Page 1) Many factors, especially mix of business, make RBC a highly individualized calculation even for companies similarly situated.

2) We appreciate the report's acknowledgement that single-state and regional companies may bear higher inherent risks and thus need to maintain substantial surplus. (Page 6) This factor is compounded where such companies are also not-for-profit. Access to capital is more limited and even where theoretically available, higher interest rates and other conditions may be added by lenders.

3) We also appreciate Lewin's independent confirmation of health plans' perception that Washington has a higher number of mandates and rules than most other states do, creating regulatory uncertainty for carriers (Page 6 footnote).

4) We found the policy discussion of "unintended consequences" of capping surplus well-taken. (Page 2 and elsewhere). The potential for legitimate spend-down of capital by carriers into technology or other operating investments could render a cap regulation theoretical in impact. Regence would also like to stress that regulating maximum surplus would invariably favor foreign (out-of-state) insurers who can move capital elsewhere in their systems, discriminating against domestic companies who cannot, discouraging formation of new domestics and potentially encouraging redomestication out of Washington.

5) On page 19, the uninsured numbers cited in an OIC news release are from the national census survey that probably overstates the number of uninsured, by asking respondents to recall whether they had ever been uninsured during a specific time period rather than whether they were uninsured at the time of the survey. Uninsured estimates from the State of Washington's Office of Financial Management are much smaller, around 9.9 percent as opposed to 14 percent, and are likely more representative of actual numbers.

6) On page 20, Lewin says "Washington lacks strong market competition." Despite a limited number of competitors in Washington compared with some other states, we dispute the implication that competition is lacking. Regence vigorously competes with all health care companies doing business in Washington and we know this is true for our carrier peers as well.

7) On page 22, Regence's offering of a statewide Medicare Part D plan through its subsidiary Asuris Northwest Health, was omitted. It is important to us to have this offering included in this report, as it represents a more accurate picture of Part D availability in this state.

8) On page 27, Medical Loss Ratios are shown by carrier. HMO loss ratios (as opposed to those of other types of carriers) may include bricks-and-mortar costs or other administrative allocations that skew the overall impression. We suggest use of a Combined Ratio instead, with a note to the reader to the effect that comparing carriers by MLR or ALR alone is inappropriate because the different structure of companies and different mix of business affect each ratio and may result in misperceptions.

   We also suggest a clarification of the effect of statutory versus GAAP reporting on traditional carriers such as Regence. ASO (self-insured) claims are not reflected in statutory accounting and thus can distort comparisons.

9) On page 28, the report discusses percent Total Administrative Costs (a combination of claim adjustment and general administrative costs). But on page 29, where dollars are used to express administrative costs, only general administrative costs are included. Shouldn't total administrative costs be used in both comparisons?

10) On page 33 in Plan Profiles, we believe Premera exited the PEBB line of business some years ago.

11) On page 34, the report refers to the previous ability of the Insurance Commissioner to "set rates" in the individual market. The Commissioner never had prior approval rate setting authority. Rather it was a file and use authority but one in which the Commissioner's office exerted so much pressure during the review process, it gave the impression of being prior approval.

12) On page 35, Lewin notes premiums for the Washington High Risk Pool are "much higher" than premiums in the individual market. They need to expand the point to explain that even though being declined for individual coverage is a pre-requisite to getting into the pool, pool benefits are much richer by state design than anything available in the individual market and that carriers and their members heavily subsidize the pool.

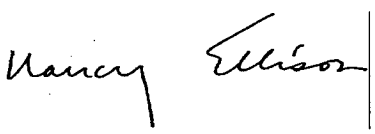
13) On Page 45, we appreciate Lewin's pointing out that Regence, among others, is not a charitable corporation, not an "insurer of last resort" and is subject to all applicable taxes, state and federal. They note that this was not the case with non-profits in some other states where capping surplus was proposed.

14) Appendix A. Lewin uses "Pricing" compared to "Surplus." It's not clear what "pricing" is. If it's meant to be premiums divided by exposures, that ignores differences in benefits. Since Surplus reflects earning from investments and lines of business not regulated by the Insurance Commissioner, "surplus" should probably be replaced with "Underwriting Gain." In Exhibit A-1 with reference to Regence, if the year 2001 is the beginning year (as it is in most of the other charts and graphs in the report), Regence would show a negative 16 percent, which would portray the large increase in 2002 in a less biased light. In fact if Lewin had used the full ten years of data submitted to the Commissioner, Regence would show break-even history at best.

15) Appendix B, organizational charts. Either all carriers should have a chart for the report, or none should. PacificCare has been excluded in the copy of the draft that we received.

Thank you again for the opportunity to comment. We want to reiterate the National Association of Insurance Commissioners' and American Society of Actuaries' cautions that risk-based capital ratios in particular are tools to assess *minimum* adequate surplus and should not be used to establish a maximum regulatory framework.

Sincerely,



Nancy Ellison, JD, DrPH
Director
Public Policy & Government Programs

Attachment D

Response by The Lewin Group

To Carrier Comments

Lewin Response to Carrier Comments

The Lewin Group appreciates the comments of PacifiCare, Premera, and Regence in response to the report *Considerations for Appropriate Surplus Accumulation in the Washington Health Insurance Market*. While we are not in agreement with all of these comments, we have provided responses to key concerns below.

PacifiCare

In response to PacifiCare's comments with regard to pages 28 and 29 on Administrative Loss Ratios (ALR), we agree that the large proportion of PacifiCare's enrollment in Medicare Advantage plans (57.9% of PacifiCare's total membership in 2005), which have disproportionately high premiums (77.6% of PacifiCare's total premium in 2005), may account for PacifiCare's lower ALR values over time relative to those of other carriers. Admin PMPM values may be affected by the relatively high administrative requirements of Medicare Advantage plans.

In response to PacifiCare's comments with regard to page 39 on Historical Profit Margin Values, we agree. Lewin brought this error to the attention of Sue Berkel, Vice President and Chief Financial Officer of PacifiCare of Washington, on December 28, 2006 via fax. We appreciate PacifiCare's confirmation of this error per its comment.

Premera

Page 3 of Premera's comments states that the Lewin report "fails to address the fundamental issue of what level of surplus is appropriate." Additionally, page 4 of Premera's comments states that the report does not quantify the likelihood or magnitude of the potential benefits and disadvantages of each policy option discussed. The Washington State Office of the Insurance Commissioner (OIC) commissioned The Lewin Group to develop a framework to review policy options within the context of how any "excess surplus" held by a domestic carrier could be regulated. Lewin was not tasked to provide specific modeling of target surplus ranges for health carriers under review, nor was Lewin tasked with quantifying the likelihood or magnitude of the potential benefits and disadvantages of each policy option discussed. A more comprehensive analysis would be required to provide the types of recommendations and conclusions that Premera seeks. This type of assessment was not within Lewin's scope of work for the OIC.

Further, page 4 of Premera's comments questions how Lewin arrived at its recommendation to examine the surplus levels of the three largest Washington carriers: Regence, Premera and GHC to assess whether they are appropriate to meet current and future business and risk management needs. Lewin provided this recommendation to avoid any regulatory action having the unintended consequence of reducing surplus of carriers that may be undercapitalized, or failing to regulate carriers that may be significantly overcapitalized, as discussed on page 46 of the Lewin report.

Pages 3 and 4 of Premera's comments with regard to page 46 of the Lewin report addresses the question of "what standard would be applied in determining whether surplus levels are

appropriate" in a surplus target range review. Premera indicated that the standard seems to be a 'we'll know it when we see it' approach. Although not stated in the report, we anticipate such a review would use either the Lewin surplus assessment model or other similar models. Under the Lewin model, to assess the sufficiency of a carrier's surplus, Lewin would conduct a series of analyses to assess the following:

- A health carrier's RBC ratio (historical, current and future) relative to minimum state and Blue Cross Blue Shield Association (when applicable) requirements

- A health carrier's RBC ratio (historical, current and future) relative to future surplus demand given reasonably predictable shifts in the underwriting cycle

The Lewin model would produce an objective, target surplus range unique to each carrier under review. The Lewin model has been used for numerous projects commissioned by the Pennsylvania Legislature, the Rhode Island Health Insurance Commissioner as well as three private Blues plans. We note that Lewin was not tasked to provide specific modeling of target surplus ranges for health carriers under review as part of Lewin's scope of work for the OIC.

Appendix A, paragraph 3 of Premera's comments states that page 29 of the Lewin report "identifies the 2005 Admin PMPM for Premera at $19," but suggests that "this value is incorrect." Premera stated that "the wrong line [line 20] from the Annual Statement was used" in this calculation. However, Lewin did not use line number 20 (Claims Adjustment Expenses) in our calculations, as indicated in Premera's comment. Lewin derived Admin PMPM values from Total Administrative Costs and Enrollment figures published in NAIC filings from 2002 through 2005. This methodology was used uniformly to derive all figures presented on page 29 of the Lewin report. We attribute the discrepancy between Premera's suggested value of $16 and our reported value of $19 to a variance in the enrollment values used in calculations.

Appendix A, paragraph 4 of Premera's comments notes that page 40 of the Lewin report "identifies the 2005 Avg. Monthly Premium for Premera as $269," but suggests that "this value is incorrect, and should be shown as $261." This statement is based on Premera's assumption that Lewin intended to use Total Revenue figures to derive these values, rather than Net Premium Income figures. Lewin's calculations used Net Premium Income figures uniformly throughout its price analyses to ensure consistency given the different types of carriers considered, contrary to the conclusion drawn by Premera. Lewin did not use Total Revenue figures because of the existence in Washington State of a group staff model HMO that receives fee-for-service (FFS) claims as revenue (GHC). These FFS claims made different carriers' Total Revenue figures incomparable. Rather than compare apples to oranges, Lewin used Net Premium Income figures in order to compare the capitated premium figures presented by all carriers.

Appendix A, paragraph 5 of Premera's comments states that in the Lewin report, the "charts on pages 35 and 36 distort Premera's results for the individual market because they both treat Premera and LifeWise Health Plan separately." We note that LifeWise is a subsidiary of Premera. It was necessary to provide figures for LifeWise separate from those of Premera to ensure consistency since Lewin had provided separate figures for the subsidiary of GHC,

Group Health Options (as indicated on pages 37 through 40 of the Lewin report). This uniform treatment across all carriers allowed for apples-to-apples comparisons among them.

Regence

Regence's comment # 8 with regard to page 27 of the Lewin report on Medical Loss Ratios (MLR) suggests use of a Combined Ratio instead of separate MLR and ALR analyses. While a Combined Loss Ratio may add value, Lewin considered MLR and ALR separately for the purposes indicated in the Lewin report on pages 26 through 28.

Further, under comment # 8, Regence also suggests that Lewin provide clarification of the effect of statutory versus GAAP reporting. In order to ensure the uniformity of data, it was necessary to analyze only one set of reported figures, either GAAP or statutory. Because Lewin intended to calculate RBC values during the course of its analyses, it was necessary to use statutory reporting; the components of RBC cannot be tracked with GAAP reporting. As a result, Lewin analyses used statutory reporting uniformly.

Regence's comment # 9 with regard to pages 28 and 29 on Administrative Costs asks whether "total administrative costs be used in both [ALR and Admin PMPM] comparisons?" The ALR figures presented on page 28 of the report have been obtained from the WA State Domestic Health Report (2005) and were not derived from any calculation performed by Lewin. The Admin PMPM figures presented on page 29 were derived from Total Administrative Costs and Enrollment figures published in NAIC filings from 2002 through 2005. In both cases, the source of the data is uniform for all carriers.

Regence's comment # 10 with regard to page 33 on Plan Profiles states "Premera exited the PEBB line of business some years ago." We agree Premera withdrew its offer of the Basic Health Plan product in June 2004, and Premera's enrollment in PEBB products declined to zero during the calendar year 2004.

Regence's comment # 14 with regard to Appendix A states that Lewin's pricing analysis "ignores differences in benefits." We agree Lewin's analysis did not account for variation within a carrier's individual product offerings. Lewin used this methodology to simplify the comparative process among carriers. If a more detailed analysis is performed as part of a comprehensive review, such differences in product offerings could be examined.

Further, Regence's comment # 14 states "if Lewin had used the full ten years of data submitted to the Commissioner, Regence would show break-even history at best." We note that data for the years 2001 and prior were not publicly available for analysis.

Attachment E

Consumer Comments

February 5, 2007

Ms Melodie Bankers
Office of the Insurance Commissioner
P O Box 40258
Olympia WA 98504-0258

Here are my comments concerning the Lewin Report regarding Surplus Accumulation in the Washington Health Insurance Market.

I am disappointed that the Lewin Group did not try to set a range of maximum surplus or compare Washington carriers with other national carriers of comparable size. Their report to the state of Pennsylvania has charts comparing Blue Cross Blue Shield organizations.

I agree with the NAIC and the Lewin group that the Risk Based Capital Ratio was not created to measure maximum surplus and should not be used to set maximum surplus levels. The report mentions months of premium, and surplus as a percent of revenue (SAPOR), I believe months of claims should be another measure. This is a better measure because the reason for surplus is to pay claims. Plus most self- funded plans reserve for months of claims. I agree there is no right level of surplus and all companies are different, but that is not a reason not to set an upper limit. If one uses months of claims the differences in types of underwriting business is taken into account. This method also prevents companies from padding administrative expenses.

One of the excuses the report and the industry give for large surpluses is the possibility of a large natural disaster. I also figured this was a reason. It is interesting to look at reality instead of theory. Hurricanes Katrina and Rita were the largest natural disasters in recent memory. What happen to Blue Cross Blue Shield of Louisiana during 2005? They had their most profitable year ever an operating income of $119 million. They also grew membership by over 32,000. They are now moderating rate increases because the New Orleans health claims are running lower than usual.

How did this happen. First most of the health care providers were forced to close. This means fewer claims. All non emergency surgeries were delayed. The military was brought in to provide medical treatment this was not billed to the carriers. Later many individuals lost their employment than their group health insurance. Individuals purchased policies increasing BCBS Louisiana membership. An interesting real life situation that shows health insurance companies did not use surplus during a very large natural disaster.

The section on to little surplus was short and discussed four failures. A failure by definition is a lack of surplus. KPS fell into negative capital the second time while under the OIC supervision because they did not purchase stop loss coverage and several large claims pulled the firm into negative capital. A bad management decision caused the failure; a simple purchase of stop loss would have kept KPS solvent. The other examples given involved bad management and suspected fraud as contributing factors for failure. I do not believe since there will be bad

decisions made in the future we need the insurance companies to hold an unneeded large levels of surplus.

The major carriers in Washington are all not for profit yet they currently have large profit margins (much larger than Wal-Mart) and pay federal income tax. This corporate structure allows management to have the policyholders' best interest in mind not shareholders. Every premium dollar that goes to surplus is taxed at the approximately 30%. Currently Premera and Regence are paying millions of dollars in federal income tax. A lower margin will save federal tax and lower the cost of insurance products. One of the goals of Premera and Regence should be a low tax bill these dollars should be used on health care not federal government taxes.

Thank you for letting me comment on this report. This is an issue that affects every citizen in the state of Washington.

Sincerely,

Curtis L Fackler
cfackler@iglide.net

Washington
Healthcare Forum

Melodie Bankers, JD
Insurance Commissioner's Office
Senior Policy Advisor, Policy Division
Rules Coordinator
Insurance Building, 2nd Floor (Capitol Campus)
302 Sid Snyder Avenue SW
P. O. Box 40258, Olympia, WA 98504-0258

Feb. 8, 2007

Dear Ms. Bankers:

Thank you for giving the Washington Healthcare Forum an opportunity to comment on the Lewin Group's report on regulation of insurer surplus. As we testified at your hearing in December of 2005, the Forum believes it's important to tackle problems in health care with comprehensive solutions. We agree with the Commissioner and others that we must foster an affordable and sustainable high quality health care system that can address the critical health care needs of all our citizens.

However, the Forum does not believe that capping capital reserves will get to the root cause of the problem and may in fact have serious unintended consequences. We also believe that instituting subjective rate regulation for individual products, utilizing subjective factors including surplus levels, is a step backward from the objective loss ratio standard which was part of the individual market reform that restored Washington's failing individual market.

In its report to your office, the Lewin Group concluded that the Office of the Insurance Commissioner should "consider examining the surplus levels of at least three of the largest Washington carriers to assess whether they are appropriate to meet current and future business and risk management needs." The report also concludes that "new requirements could create new financial risks and increase uncertainty around surplus demand." In its study for the state of Pennsylvania, the Lewin Group found that very few states regulate the upper bounds of surplus capital. According to their report, there is no consensus about the right level of surplus for a health insurer; rather it's a matter of judgment. The National Association of Insurance Commissioners only addresses the minimum amount required to remain solvent and agrees that there is "no formula available that says how much capital is "good," how much is "better," or how much is "best."

We count on your office to make sure that health plans are themselves healthy and that's why previous discussions have centered on the minimum amount plans need to remain viable and solvent. As the Lewin Group study reported, our not for profit plans have no access to capital outside of the money they charge for premiums. With that money, they must provide for our health care needs and they must have the infrastructure to be efficient and effective. They need to invest in technology, to respond to the growing demands from government and the private sector. The Forum believes that the people who run the plans, their Boards and their leaders, are best positioned to manage their capital in the interests of their members.

Disaster strikes without any warning. Whether it's Hurricane Katrina, a bird flu pandemic or an earthquake, our health plans, both for profit and not for profit, must be ready to care for our citizens. And in some disasters their ability to collect premiums could be temporarily suspended. Any of these scenarios could require the capital reserves our health plans have today. These reserves are our safety net.

The Washington State Blue Ribbon Commission carefully studied our health care system and developed a series of recommendations for improvement. We strongly favor this comprehensive, thoughtful approach. Two items in particular, reform of the high risk pool and increasing coverage for kids, are high on our agenda. We encourage the OIC to take actions that are consistent with this report.

If you have questions or would like to discuss this further please contact Don Brennan, Forum chair, at 425/641-0604.

Sincerely,

Abbi Kaplan

The Forum is a coalition of physicians, hospitals, health plans, and purchasers that is working to improve the health care system. Our mission is to streamline and simplify healthcare financing and delivery across the state and to advance a public dialogue on sustainable solutions to the challenges facing the health care system. (For more information on the Forum, please see our website at www.wahealthcareforum.org)

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Insurance Commissioner

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February 28, 2007

Melodie Bankers
Senior Policy Advisor
Office of the Insurance Commissioner
Policy Division
PO Box 40258
Olympia WA 98504-0258

Re: Comments on *Policy Options Regarding Surplus Accumulation in the Washington Health Insurance Market*

Dear Ms. Bankers,

On behalf of Washington State insurance consumers and in cooperation with and support of the consumer advocates listed below, thank you for this opportunity to provide *comments on* the January 25, 2007 Lewin Group report, *Policy Options Regarding Surplus Accumulation in the Washington Health Insurance Market.* We thank you as well for the opportunity to participate in the Insurance Commissioner's December 8, 2005 *Informational Hearing on Regulation of Insurer Surplus* and to be interviewed during the Lewin Group's study.

At its heart, insurance regulation is consumer protection. Indeed, on the Insurance Commissioner's website we can read that "the Insurance Commissioner's Office has the responsibility of regulating the insurance business in Washington" and that "consumer protection is the most important job of the Insurance Commissioner."

As health insurance costs rise and fewer state employers and residents can afford to maintain adequate private coverage, it is critically important that our health insurance market operates fairly for consumers, while it operates efficiently for the carriers. We look to the Washington State Insurance Commissioner, as our principal insurance market regulator, to assure us that the market does and will continue to do so.

Of course, our economy is dynamic as is our state's insurance industry; which has changed over the years, To the detriment of consumers, it is economically inefficient. With three nonprofit carriers dominating our market, limited competition has provided these carriers with increased negotiating leverage over customers and providers. Through modern actuarial and underwriting techniques, insurance carriers are considerably better able to predict costs, price products, and remain profitable over longer periods of time. The state's individual insurance market is

structured in a way that essentially guarantees carrier profits. These factors must be recognized and incorporated into our Insurance Commissioner's regulatory work and we agree with the Lewin Group when they write that "the OIC should examine the surplus levels of at least the three largest Washington carriers."

We have now experienced six years of extraordinary industry-wide profits. Surpluses are at alltime highs and clearly have reached unreasonable and unnecessary levels. Sadly, the burden of carrier surplus along with the absence of regulatory action in our economically inefficient insurance market, is borne by policyholders paying too-high premiums and by consumers who cannot afford any coverage at all.

Thus, we applaud the commissioning of The Lewin Group to develop methods to assess whether Washington's carriers have excess surplus and how any excess surplus could be regulated. Their report presents reasonable and balanced analysis and four policy options with regard to surplus regulation that have merit and applicability to the different circumstances that we now face or may face in the future. We urge the OIC to use this study as a mandate to move forward in examining and ultimately regulating surplus levels.

As we stated in our December 2005 testimony and restate today, we would support swift regulatory action, perhaps in the form of refunds to policyholders in any case where a particular carrier's surplus level is egregiously high and clearly unnecessary. However, we believe that the most reasonable long-term benefits will come through "financial transparency" and rate regulation that factors in a carrier's surplus level. This is entirely consistent with The Lewin Group report.

The Lewin Group states that "focusing on increased transparency can improve competition and efficiency while stronger regulatory authority and oversight can provide the first step in addressing concerns of surplus accumulation." Further, they state that "enhancing an Insurance Commissioner's regulatory authority...can provide a stronger platform for regulatory oversight and scrutiny of health carrier surplus accumulation."

We firmly agree and suggest that through the regulatory process, if the OIC determines that a carrier's surpluses are excessive, it should hold public hearings on whether rates should be reduced, or surplus money invested into systems (e.g., electronic records), used to capitalize reinsurance programs, or distributed as a community benefit to safety net providers.

Because no simple formulas are available, we propose that the Washington State Insurance Commissioner be empowered to identify, as The Lewin Group suggests, "appropriate surplus ranges for each carrier, rather than specific target surplus levels." However, simply because there are no easy answers at present to the measure of "appropriate surplus ranges," it would not be right to suggest that the OIC should not move forward with legislation or regulation of surplus in rate-setting without further study. As The Lewin Group proposes, the OIC should incorporate the use of "additional market analysis and review...in any type of rate regulation review and

approval process" and indeed, this analysis and review can be called for in the necessary empowering legislation.

Thank you again for the opportunity to participate in this important process. Although we have been labeled by carrier representatives as "special interests" with "unspecified and vague concerns," our consumer advocacy on the issue of carrier surplus has been consistent and clearly articulated. On behalf of all Washington state consumers - government, employers, employees and individuals - our position simply advocates for timely regulation of excesses, and we have consistently attempted to take a reasonable and prudent approach to this issue. We do not want the carriers to operate at dangerous financial levels.

Like The Lewin Group, we do not believe that there are simple answers or that across-the-board, solutions are appropriate. We have turned to the Insurance Commissioner to act on behalf of all consumers, recognizing that a carrier-specific approach is most appropriate and that the regulatory work will require a sophisticated analysis. But there must be a reasonable point for each carrier where enough is simply enough.

Sean P, Corry, Sprague Israel Gill, Inc.

Also on behalf of:

Bill Daley, Washington .Community Action Network Robby Stern,

Washington State Labor Council Janet Varon, Northwest Health

Law Advocates David West, Center for a Changing Workforce

Date: March 14, 2007

To: Melodie Bankers

From: Brian C. McCulloch

Re: The Lewin Report

The Lewin Report reminds me of an old commercial's tagline - "Where's The Beef"? At $400 per hour, the authors would have had to spend 250 hours on the Report. $100,000 seems an unlikely sum given its length and content. Further, there appears to be a fair amount of "sharing" with reports the firm has done for other states.

For the most part, it is compilation of the some of the literature surrounding the issue of health insurer surplus. Unfortunately, even this is not complete and a number of significant sources and events are missed.

While there is some Washington specific information, a good deal of the material in the report appears to have come from a similar Lewin generated document regarding health insurer surpluses in Pennsylvania. Further, the Report completely misses several key points, some local and others of a national nature.

In addition to being late, the Report reaches no conclusion as to how much surplus is too much. Apparently, it was suggested that more money might get a more definitive answer to the question.

No mention is made of well-established actuarial standards for adequately funded health plans, other than to say that stock carriers operate on significantly lower surplus than Washington's domestic carriers. And, it does state that the national companies are some of the largest in the business.

By way of comparison, a study performed the Oregon Department of Insurance reaches the conclusion that a number of Oregon carriers have more than enough in the way of reserves and surplus. The Oregon Regence and Premera affiliates merited special mention, even though the

surplus amounts are significantly less than the much larger plans in Washington.

Another issue that needs to be addressed is the furnishing of copies of the entire Report to some of the domestic health insurers before its release to the public and especially to those who had been requesting it. Included in those who had to wait were legislators, members of the media and interested individuals. The carriers should have had chance to review the numbers for accuracy, not the entire report.

That said, the remarks made by several of the carriers are telling. Premera's call for combining Premera and Lifewise enrollment figures should be accommodated by requiring that Lifewise of Washington be acquired by its parent. Regence's statement that Washington has a competitive market is absurd on its face. To say that the process was not legitimate speaks volumes about the management attitudes.

In the end, the Lewin Report does not provide the cover the Office of Insurance Commissioner seems to have been seeking. Perhaps, the results should have been expected given that the bid specifications led to single bidders to the OIC's two RFP's. The specifications virtually excluded anyone in the state of Washington with the requisite skill set needed and interest in the job.

Finally, there is no mention of I-346 or HB1203, although an oblique reference to both is contained in the more recently released Rhode Island version. Given the fact that the I-346 caused the Insurance Commissioner to take up the surplus issue in the first place, silence on the subject shows the shortcomings of the Lewin Report may go beyond its authors. Given the delay in its delivery, HB 1203 had been filed and was available to Lewin.

The bottom line is that the Insurance Commissioner should seek a refund. This amount should be based on the time taken to prepare and write the Washington specific information, at the various and presumably reasonable billing rates of the Lewin staff involved.

Oh, and the year numbers are in. The big three increased surplus by almost $400 million. The refund resulting from HB 1203 would come close $1.3 billion. This amount tops the amount of states studied by Lewin.